

# Inspector General

United States  
Department of Defense



## Special Plans and Operations

### Assessment of DoD Wounded Warrior Matters - Joint Base Lewis-McChord

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# Inspector General

## United States Department of Defense

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**INSPECTOR GENERAL**  
DEPARTMENT OF DEFENSE  
4800 MARK CENTER DRIVE  
ALEXANDRIA, VIRGINIA 22350-1500

May 31, 2013

MEMORANDUM FOR DISTRIBUTION

SUBJECT: "Assessment of DoD Wounded Warrior Matters – Joint Base Lewis-McChord"  
(Report No. DODIG-2013-087)

This report discusses the U.S. Army's Warrior Care and Transition Programs at Joint Base Lewis-McChord, Washington and is the sixth site report to discuss the care, management, and transition of recovering Service members.

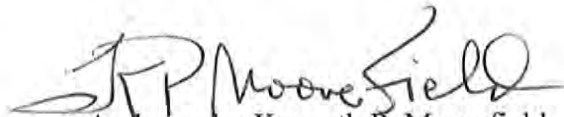
We are providing this report for review and comment. We considered management comments on a draft of this report when preparing the final report. While all comments were responsive, several comments require additional supportive information.

We request additional comments on recommendations by June 30, 2013 as follows:

- Under Secretary of Defense for Personnel and Readiness: We request additional comments on Recommendation C.4.1.
- Warrior Transition Command: We request additional comments in support of Recommendations C.1.1., C.1.2., C.2.1.a., C.2.1.b., C.3.1.a, C.3.1.b., and C.4.2.
- United States Army Medical Department Center and School: We request additional comments on Recommendation C.1.2.

DOD Directive 7650.3 requires that recommendations be resolved promptly. If possible, send a .pdf file containing your comments in electronic format (Adobe Acrobat file only) to [spo@dodig.mil](mailto:spo@dodig.mil). Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to our staff during the conduct of this project. Please

  
Ambassador Kenneth P. Moorefield  
Deputy Inspector General  
Special Plans and Operations

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# **Results in Brief: Assessment of DoD Wounded Warrior Matters – Joint Base Lewis-McChord**

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## **What We Did**

We assessed whether the programs for the care, management, and transition of Soldiers in the Warrior Transition Battalion, Joint Base Lewis-McChord, Washington (hereafter the Warrior Transition Battalion [WTB]) were managed effectively and efficiently. Specifically, we evaluated the missions, policies, and processes in place to assist Warriors in Transition with their return to duty status or transition to civilian life, and the DoD programs for Service members affected with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).

## **What We Found**

We identified several initiatives implemented at both the WTB and Madigan Army Medical Center (MAMC) that we believed to be noteworthy practices for supporting the comprehensive care, healing, and transition of Soldiers.

We also identified a number of significant challenges that we recommend the Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of the Army, Manpower and Reserve Affairs; Commander, Human Resources Command (HRC); Western Regional Medical Command (WRMC); Commander, United States Army Medical Department Center and School; Warrior Transition Command (WTC); MAMC and WTB leadership address, and which if resolved, should increase program effectiveness.

## **What We Recommend**

We recommend that the Under Secretary of Defense for Personnel and Readiness; Assistant Secretary of the Army, Manpower and Reserve Affairs; HRC; WRMC; United States Army Medical Department Center and School; WTC; MAMC and WTB leadership:

- Develop policy guidance for Reserve Component (RC) Soldiers who volunteer for WTB positions to attend training prior to, or in route to their assignment at the WTB
- Periodically evaluate the effectiveness of the WTB leadership and cadre training curricula to ensure it is relevant and meets the needs of WTB staff
- Evaluate current and future manning requirements of WTBs to ensure they are appropriately staffed to meet the mission and have experienced cadre in place to effectively manage and support Soldiers during their healing and transition
- Conduct an analysis to determine if WTBs have adequate resources and funding to support appropriate manpower levels, ongoing staff training requirements, and support services in order to maintain staffing levels/ ratios to meet the mission
- Review the Comprehensive Transition Plan policy and guidance for relevant and effective content in supporting Soldier transition needs

- Complete the migration of the Comprehensive Transition Plan from the Army Knowledge Online to the Army Warrior Care and Transition System
- Evaluate the effectiveness of the WTB leadership and cadre in actively engaging the Soldiers' CTP and encourage Soldiers' involvement and adherence to the plan for a successful transition
- Publish and implement DoD guidance for expanding Soldier internships to include Non-Federal opportunities
- Update command policies and provide interim measures to allow Soldiers assigned or attached to the WTB to participate in Non-Federal internship opportunities
- Track each phase of the Integrated Disability Evaluation System (IDES) process over time to identify and act upon barriers to timely IDES completion for Soldiers assigned or attached to WTBs
- Identify obstacles that inhibit prompt Medical Evaluation Board (MEB) completion, and request personnel resources that will eliminate the MEB backlog; acquire sufficient space to support staff requirements for effective MEB processing
- Educate Soldiers and families on the IDES process; establish a means for Soldiers' to track or be informed of his or her status in the IDES process
- Conduct an analysis to determine obstacles to specialty care access and delays encountered and then take appropriate steps to ensure WTB Soldiers' access to all specialty care meets or exceeds the Army Enhanced Access to Care standards

## **Management Comments and Our Response**

Those offices listed on the recommendations table concurred with comments to our recommendations. Responses to seven recommendations were responsive and require no further action. Responses to eight recommendations were responsive, however, requiring additional comments. Therefore, we request additional comments on these eight recommendations by June 30, 2013.

See Recommendations Table on page iii of this report.

## Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Under Secretary of Defense for Personnel and Readiness	C.4.1.	
Assistant Secretary of the Army, Manpower and Reserve Affairs		C.2.1.a., C.2.1.b.
Commander, Human Resources Command		C.1.1
Commander, Western Regional Medical Command		D.1.1.
Commander, United States Army Medical Department Center and School	C.1.2	
Commander, Warrior Transition Command	C.1.1., C.1.2., C.2.1.a., C.2.1.b., C.3.1.a., C.3.1.b., C.4.2.	
Commander, Madigan Army Medical Center		D.1.2.a., D.1.2.b., D.1.2.c., D.1.2.d., D.2.
Commander, Warrior Transition Battalion		C.3.2.

**Please provide comments by June 30, 2013.**



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# Introduction

## Objectives

The broad objective of this ongoing assessment is to determine whether the DoD programs for the care, management, and transition of recovering Service members wounded during deployment in Operation Iraqi Freedom or Operation Enduring Freedom were managed effectively and efficiently.<sup>1</sup>

## *Specific Objectives*

Our specific objectives were to evaluate the missions, the policies, and processes of:

- Military units, beginning with the Army and Marine Corps, established to support the recovery of Service members and their transition to duty status (Active or Reserve Components)<sup>2</sup> or to civilian life; and
- DoD programs for Service members affected with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).

## *Assessment Approach*

This is the sixth of six site assessments conducted at Army and Marine Corps Warrior Transition Units. This assessment addressed the wounded, ill, or injured Soldiers' matters at the Army Warrior Transition Battalion (hereafter, "WTB") located at Joint Base Lewis-McChord (JBLM), Washington. To obtain unbiased data, not unduly reflecting the views of either the supporters or detractors of the program, we used a two-pronged approach to select our respondents. First, we determined how many Service members were required to be interviewed, and secondly, we applied a simple random sample approach to determine the Service members we should interview, as described in Appendix A. Subsequently, we interviewed 60 individual Soldiers and 26 additional Soldiers in 4 group interviews.

Additionally, we interviewed all available members of the key groups at JBLM responsible for the Soldiers' care. Specifically, we conducted meetings and interviews during our 2-week visit to JBLM that included Madigan Army Medical Center (MAMC) and WTB military and civilian staff, and contractors supporting the WTB. A list of the meetings conducted at the WTB JBLM and MAMC – Madigan Healthcare System (MHS) located at JBLM, from June 14-24, 2011 is shown in Appendix A, along with the scope, methodology, and acronyms of this assessment. Prior coverage of this subject area is discussed in Appendix B.

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<sup>1</sup> Subsequent to our project announcement and at the initiation of our fieldwork, the Army's Warrior Transition Command (WTC) informed us that approximately 10 percent of the Soldiers assigned or attached to Warrior Transition Units (WTUs) were combat wounded.

<sup>2</sup> The Army consists of two distinct and equally important components, the Active Component and the Reserve Component (Army National Guard and the Army Reserve).

The observations and corresponding recommendations in this report focus on what we learned at JBLM concerning its Wounded Warrior program. We believe that some of our observations may have implications for other Warrior Transition Units (WTUs) and WTBs and should be called to the attention of those responsible for these programs.

Additional reports and/or assessments may be subsequently performed by the DoD Office of Inspector General on DoD Wounded Warrior matters or other related issues as they are identified. Any specific Wounded Warrior issues, concerns, and challenges that we identified at JBLM that may have to be addressed in future assessments and/or reports are discussed in Appendix C.

## **Background**

According to the Army's Warrior Transition Command (WTC), on September 1, 2012, there were 9,852 Warriors in Transition in the Army WTUs and Community Based Warrior Transition Units (CBWTUs).<sup>3</sup> Over 1,000 were wounded in combat, approximately 2,000 were injured or became sick and were medically evacuated<sup>4</sup> from theater, and approximately 2,100 returned from a deployment prior to entry into a WTU but were not medically evacuated during the deployment. Of the remaining 4,716 Soldiers who had not deployed within the last 6 months, 3,492 had deployed one or more times and 1,224 had never deployed.<sup>5</sup>

## **Army Guidance**

Army guidance for the care and management of Warriors in Transition is contained in the "Warrior Transition Unit Consolidated Guidance (Administrative)," March 20, 2009 (hereafter, "Consolidated Guidance"). The purpose of the Consolidated Guidance is to prescribe the policies and procedures for the administration of Soldiers assigned or attached to WTUs. The Consolidated Guidance addresses items such as eligibility criteria for a Soldier's assignment or attachment to a WTU; staffing ratios of Army care team members; and other administrative procedures for Soldiers being considered for assignment or attachment to a WTU. For additional information on the Consolidated Guidance, see Appendix D for summary description.

After our visit, the WTC updated their policy related to the Comprehensive Transition Plan (CTP) for Soldiers assigned/attached to WTUs and CBWTUs; and formalized a review process that facilitates the Soldiers progression through the WTU/CBWTU. The updated CTP Policy and Guidance, December 1, 2011, is explained in further detail in Parts I, II and Appendix E of this report.

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<sup>3</sup> Community-Based WTUs are primarily for Reserve Component Soldiers. According to the Consolidated Guidance, the Community-Based WTU is a program that allows Warriors to live at home and perform duty at a location near home while receiving medical care from the Tricare network, the Department of Veterans Affairs, or Military Treatment Facility (MTF) providers in or near the Soldier's community.

<sup>4</sup> Medical evacuation is defined as to transport a patient to a place where medical care is available.

<sup>5</sup> Figures provided by the Army WTC, Program Performance and Effectiveness Branch, September 10, 2012.



## ***Warriors in Transition***

The Army's wounded, ill, and injured Service members were referred to as Warriors in Transition (WTs) at the time of our site visit. The mission statement of a Warrior in Transition is:

I am a Warrior in Transition. My job is to heal as I transition back to duty or continue serving the nation as a Veteran in my community. This is not a status but a mission. I will succeed in this mission because

I AM A WARRIOR AND I AM ARMY STRONG.

As of December 1, 2011, the Army replaced the term "Warrior in Transition" with "Soldier."

## ***Warrior Transition Units***

In 2007, the Army created 35 WTUs at major Army installations primarily in the Continental United States (CONUS) and at other sites outside CONUS to better support the recovery process of the Army's wounded, ill, and injured Service members. As of December 2011, there were 28 WTUs located in CONUS, 1 in Hawaii, 1 in Alaska, and 2 in Europe, as well as, 8 Community-Based WTUs located in CONUS and 1 in Puerto Rico.

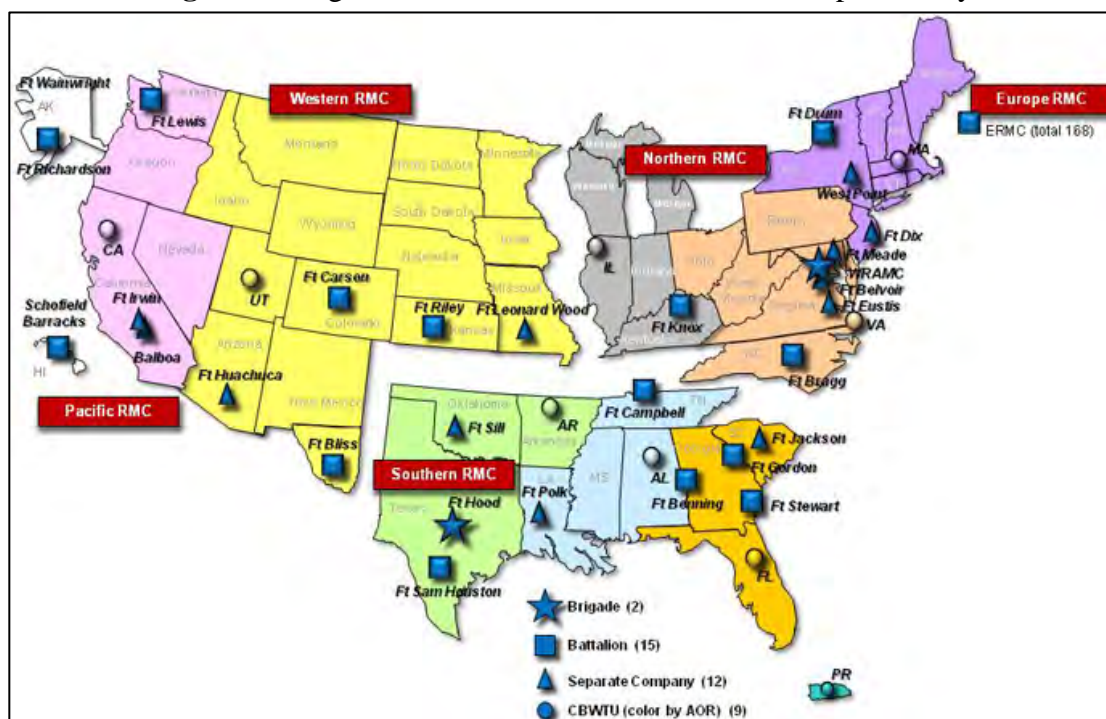
A WTU is a company level unit and a WTB includes multiple companies or CBWTUs. A WTB is commanded by a field grade officer (typically a Lieutenant Colonel)<sup>6</sup> with multiple companies or CBWTUs that report to him or her. The unit located at JBLM is a battalion size unit and is a WTB. Additionally, WTC policy uses WTU to refer to all units including the WTB. Therefore, throughout this report we will refer to WTU when citing general policy applications and WTB when specifically referring to the WTB at JBLM.

Figure 1 illustrates the Regional Medical Commands Area of Responsibility and their geographically aligned CBWTUs, to include WRMC.

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<sup>6</sup> A military officer, such as a major, lieutenant colonel, or colonel, ranking above a captain and below a brigadier general.

**Figure 1. Regional Medical Commands Area of Responsibility**



Source: Warrior Transition Command – December 2011

The commander of each WTB reports to the commander of the Military Treatment Facility (MTF) to which its Soldiers are assigned. Army WTB care teams consist of, but are not limited to, military staff, physicians, nurses, behavioral health specialists such as psychologists and social workers, occupational therapists, including civilians and outside organizations offering resources to the Soldiers in support of mission accomplishment.

WTUs provide support to Soldiers who meet the eligibility criteria, which generally require that: (1) a Soldier has a temporary physical profile,<sup>7</sup> or is anticipated to receive a profile, for more than six months with duty limitations that preclude the Soldier from training for or contributing to unit mission accomplishment, and (2) the acuity of the wound, illness, or injury requires clinical case management to ensure appropriate, timely, and effective utilization of and access to medical care services to support healing and rehabilitation.<sup>8</sup>

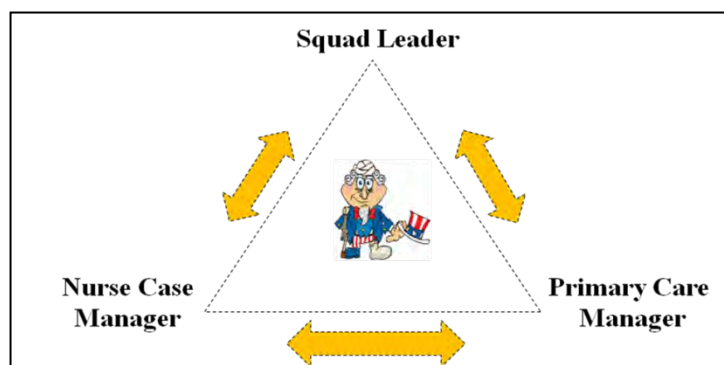
<sup>7</sup> According to Army Regulation 40-501, “Standards of Medical Fitness,” December 14, 2007, the basic purpose of the physical profile serial is to provide an index to overall functional capacity. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. The six factors that are evaluated are: physical capacity or stamina, upper extremities, lower extremities, hearing and ears, eyes, and psychiatric. Profiles can be either permanent or temporary.

<sup>8</sup> Army National Guard and Army Reserve Soldiers may be eligible for assignment or attachment to a WTU but fall under a different and more complex process than Active Component Soldiers. The processes are shown in the Consolidated Guidance.

## Triad of Care

The Army established the Triad of Care concept to envelop the Soldiers and their families in comprehensive care and support, which is focused on each Soldier's primary mission – to heal and transition. The “Triad of Care” consists of a squad leader, a nurse case manager (NCM), and a primary care manager (PCM). Within the “Triad,” the squad leader leads Soldiers, the nurse case manager coordinates their care, and the primary care manager oversees the care. Specifically, the Triad of Care works together as a team<sup>9</sup> to collect Soldier data and information and develop a plan of care specific to each Soldier. The plan of care addresses medical treatment, administrative requirements, support needs, and disposition. The intent is for all of these elements to work together to ensure advocacy for the Soldiers, continuity of care, and a seamless transition back into the force or to a productive civilian life. The Triad of Care structure is shown in Figure 2.

Figure 2. Triad of Care



Source: Brooke Army Medical Center, Warrior Transition Battalion Handbook, June 2010

Fragmentary Order (FRAGO) 3 to Execution Order (EXORD) 188-07, March 20, 2009, established the WTU Triad of Care staff to Soldiers ratios at: squad leader (1:10), nurse case manager (1:20), and primary care manager (1:200).

The following is a brief description of each Triad of Care member's roles and responsibilities.

- **Squad Leader** – traditionally a Non-Commissioned Officer (NCO) in the rank of Sergeant (E-5) or Staff Sergeant (E-6) and is the first line supervisor for all Soldiers. Their duty description includes, but is not limited to: accounting for Soldiers daily, counseling them and guiding them in their Comprehensive Transition Plan (CTP),<sup>10</sup>

<sup>9</sup> According to the December 1, 2011 Comprehensive Transition Policy and Guidance, the inter-disciplinary team includes the WTU clinical and non-clinical team members that consist of the Triad of Care (Squad Leader, Nurse Case Manager, and Primary Care Manager) along with the Occupational Therapist Registered (OTR), Certified Occupational Therapy Assistant (COTA), Physical Therapy Assistant (PTA), Clinical Social Worker (CSW), Army Wounded Warrior Advocate, Soldier and Family Assistant Center (SFAC) personnel and Transition Coordinators.

<sup>10</sup> The CTP supports Soldiers in returning to the force or transitioning to a Veterans' status. Although standardized, the CTP allows each Soldier to customize his/her recovery process, enabling them to set and reach their personal goals with the support of the WTU cadre. For additional information on the CTP, see Observations A, C and Appendix E.

ensuring that they attend all appointments, tracking all of their administrative requirements, and building trust and bonding with Soldiers and their families.

- **Nurse Case Manager (NCM)** – a civilian or Army military nurse who provides the individualized attention needed to support the medical treatment, recovery, and rehabilitation phases of care of the Soldiers. The goal of case management is to orchestrate the best care for the Soldiers by monitoring progression of care, Transition Review Board<sup>11</sup> recommendations, and Soldiers' respective goals to facilitate transition of the Soldier from one level of care to the next.
- **Primary Care Manager (PCM)** – is either a military or civilian healthcare provider (e.g. Physician, Physician Assistant, or Nurse Practitioner) who is the medical point of contact and healthcare advocate for the Soldier. They provide primary oversight and continuity of healthcare and are to ensure the level of care provided is of the highest quality. They are the gateway to all specialty care (such as behavioral health specialists or orthopedic surgeons) and they coordinate with other care providers to ensure that the Soldiers are getting the treatment that they need.

### ***Joint Base Lewis-McChord***

JBLM,<sup>12</sup> Washington is one of 12 joint bases created by the 2005 Base Realignment and Closure<sup>13</sup> Commission. The joint base includes Fort Lewis and McChord Air Force Base. The JBLM community consists of 36,668 military, 11,324 civilians and 53,033 family members.

Army units assigned to JBLM include: I Corps;<sup>14</sup> 2nd Brigade, 2nd Infantry Division; 3rd Brigade, 2nd Infantry Division; 4th Brigade, 2nd Infantry Division; 17th Fires Brigade; and resident units such as the 1st Special Forces Group (Airborne); the 2nd Battalion, 75th Ranger Regiment; 8th Brigade, U.S. Army Cadet Command; Western Regional Medical Command (WRMC); Madigan Army Medical Center (MAMC); and several other non-divisional support units.

Air Force units assigned to JBLM include: 62nd Airlift Wing, Air Mobility Command; Air Force Special Operations Command; 446th Airlift Wing, Air Force Reserve Command; Western Air Defense Sector and 262nd Network Warfare Squadron, Washington Air Guard, 22nd Special Tactics Squadron and the 627th Air Base Group.

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<sup>11</sup> Transition Review Boards are intended to facilitate dialogue between the Warrior and the Triad of Care, chain of command, and other members of the Warrior's care team, as appropriate, regarding both the Comprehensive Transition Plan progress and future strategy for the Warrior's transition.

<sup>12</sup> Figures and information, Joint Base Lewis-McChord 2012 Base Guide and Directory

<sup>13</sup> "BRAC" is an acronym which stands for base realignment and closure. It is the process DoD has previously used to reorganize its installation infrastructure to more efficiently and effectively support its forces, increase operational readiness and facilitate new ways of doing business.

<sup>14</sup> First Corps is one of the four Corps headquarters in the active Army, and one of three based in the continental United States. I Corps has been designated as one of the active Army's contingency corps, and stays prepared to deploy on short notice worldwide to command up to five divisions or a joint task force.

Joint Base Lewis-McChord is a training and mobilization center for all services, and the only Army power-projection platform west of the Rocky Mountains. JBLM has a sub-installation at Yakima Training Center located in eastern Washington State.

## ***Surrounding Area***

JBLM is located about 12 miles from Olympia, Washington's capital. The metro area, including the communities of Lacey and Tumwater, has a population of more than 88,000. The nearby Providence St. Peter Hospital is a 390-bed, not-for-profit regional teaching hospital offering comprehensive medical, surgical and behavioral health services.

Tacoma, located north of JBLM, approximately 15 miles, is the largest city close to the base, with a population of about 200,000. It offers an abundance of cultural resources and a University of Washington campus. St. Joseph Medical Center is a 343-bed regional medical center, home to the South Sound's largest heart and vascular center, a Level II Trauma Center and other advanced programs.

The nearest large city (Seattle, WA) is approximately 50 miles north of JBLM and has a population of approximately 602,000. Seattle is home to Harborview Medical Center, one of the nation's leading hospitals and the only Level I adult and pediatric trauma and burn center serving Washington, Alaska, Montana, and Idaho. The medical center offers highly specialized services such as trauma and burn care, as well as neurosurgery, eye care, vascular, rehabilitation, sleep medicine (sleep apnea) and spine care.

The VA Puget Sound Health Care System located in Seattle offers a variety of services to include: diagnostic imaging, emergency and urgent care services, and mental health, to include PTSD programs, and rehabilitation care and spinal cord injury services. VA Medical Centers are located in Spokane, WA, Portland, OR, and Boise, ID. In addition, a Vet Center is located in Tacoma, WA, offering counseling, family therapy and outreach services Monday through Friday and upon request.

## ***Western Regional Medical Command***

JBLM is the central headquarters for The Western Regional Medical Command (WRMC). The Command covers 20 states, and is geographically the largest of the Army's three regional medical commands in CONUS. The two-star Commanding General has oversight of nine Army medical treatment facilities, two medical detachments, and other medical assets within the region. The Commanding General, WRMC also provides oversight for the health care delivery process of Active, and Reserve Component Soldiers, retirees, and their families.

There are 10 WTUs in the WRMC serving over 2,000 Soldiers, and two CBWTUs. As of April 6, 2012, CBWTU-California oversees approximately 268 Soldiers receiving care across California, Nevada, Oregon and Washington. CBWTU-Utah manages the care of approximately 215 Soldiers, covering 13 western and central states.

## ***Madigan Army Medical Center – Madigan Healthcare System***

Headquartered at Madigan Army Medical Center (MAMC) on JBLM, the Madigan Healthcare System is a network of Army medical facilities located throughout Washington, Oregon, and



California which serve more than 109,000 active duty service members, their families and retirees. MAMC is a 200-bed facility offering a variety of patient care services to include: medical and surgical care, patient-centered adult and pediatric primary care, 24-hour emergency care, specialty clinics, clinical services, and behavioral health and wellness services.

MAMC supports 34 Graduate Medical Education (GME)<sup>15</sup> programs; has enrolled approximately 552 trainees, interns, residents, and fellows; and has supported 548 Medical Student Clerkships annually. Additional programs included: Nursing and Enlisted Medic education; Civilian education (e.g., Bachelor of Science in Nursing, Associate of Science Degree in Nursing and Licensed Practical Nursing programs) as well as graduate nursing students and numerous technical programs.

Finally, MAMC through the use of the Anderson Simulation Center (ASC) has provided training to over 29,000 medical personnel since 2002. Training opportunities included: basic medical skills training and trauma skills (scenarios) training; hosted training in Advanced Cardiac and Trauma and Pediatric Life Support, and Trauma Nursing Core and Emergency Nursing Pediatric Courses. The ASC staff has also supported off-site training to units during field exercises and at MAMC. The Andersen Center was re-accredited as a Level 1 (highest level) Education Center by the American College of Surgeons in 2008 and is the first and only DoD center to obtain this accreditation and one of less than 20 hospitals to do so in the U.S.

### ***Warrior Transition Battalion (JBLM)***

In 2007, MAMC activated the Warrior Transition Battalion for wounded, ill, and injured Soldiers. The mission of the JBLM WTB, also known as “Phoenix Battalion,” is to provide command and control, primary care, and case management for Soldiers in Transition to establish conditions for their healing and to promote their timely return to the force or transition to civilian life.

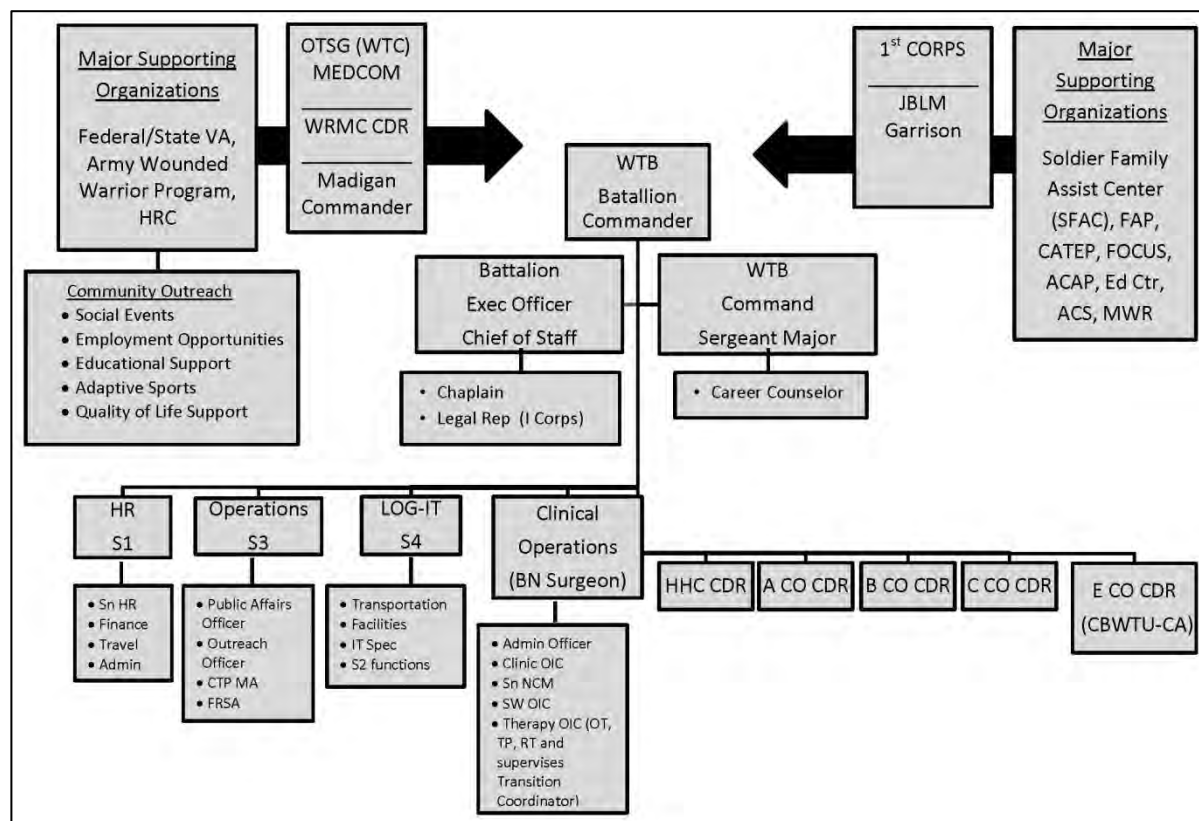
The WTB also provides oversight to a CBWTU which allows Guard and Reserve Soldiers to live with their families and receive local healthcare in communities not near Army medical facilities. The WTB also partnered with the U.S. Department of Veterans Affairs and other governmental agencies to enhance the care and service of Soldiers and families at both national and local levels.

As of June 21, 2011, the JBLM WTB staff population was approximately 109 military members, with 33 staff assigned to the CBWTU-CA. The WTB consisted of a headquarters company (HHC) and four additional companies (Alpha, Bravo and Charlie companies, along with E Co or CBWTU-CA) that collectively provided unit leadership and focused on meeting the command and control functions. The JBLM Warrior Transition Battalion Organization is illustrated in Figure 3.

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<sup>15</sup> Any type of formal, usually hospital-sponsored or hospital-based training and education, that follows graduation from a medical school, including internship, residency, or fellowship.

**Figure 3. JBLM Warrior Transition Battalion Organization**



Source: Recreated by DoD IG SPO from Joint Base Lewis-McChord Warrior Transition Battalion slides, June 14, 2011

The JBLM WTB Clinical Operations included a nurse case management staff, a battalion surgeon, primary care managers, and a clinical pharmacist. Social Workers and occupational therapists were also physically located at the JBLM WTB.

Subsequent to our visit, Soldiers relocated to a new Warrior Transition Battalion Complex (September 2011) adjacent to MAMC. The Complex has 408 “1 plus 1” suites and single rooms, to include 42 disability friendly rooms for Soldiers. The JBLM WTB Administration Building, which opened January 8, 2013, supports Warrior Transition services, to include four Warrior Transition Companies and the Soldier and Family Assistance Center (SFAC).<sup>16</sup>

Between June 1, 2007,<sup>17</sup> and December 31, 2012, JBLM WTB had over 2,600 Soldiers complete their program. Table 1 shows the total Soldiers by Component who have transitioned.

<sup>16</sup> The Soldier and Family Assistance Center (SFAC), delivers on-site streamlined non-medical services to Soldiers and their family members as they heal and prepare for transition.

<sup>17</sup> June 1, 2007, is the date that the U.S. Army WTC was officially activated.

**Table 1. Soldiers Who Transitioned Through the Joint Base  
Lewis-McChord WTB Between June 1, 2007, and December 31, 2012**

Active Component	1,482
National Guard	826
Reservist	389
<b>Total Soldiers</b>	<b>2,697</b>

*Source: Figures provided by the Army WTC, Program Performance and Effectiveness  
Branch, February 2013*

At the time of our visit there were 451 Soldiers assigned to the JBLM WTB; 207 Active Duty, 168 National Guard, and 76 Reservists. Of the 451 Soldiers assigned, 67 were combat wounded;<sup>18</sup> 384 were non-battle injury<sup>19</sup> related, and 123 Soldiers had injuries related to PTSD<sup>20</sup> or TBI.<sup>21</sup> Additionally, 250 Soldiers were assigned to CBWTU-CA, two Active Component Soldiers, and 248 Reserve Component Soldiers.

### ***Traumatic Brain Injury and Post Traumatic Stress Disorder***

TBI and PTSD are increasingly common diagnoses for recovering Service members. TBI is also referred to by its common term, “concussion,” which is when someone receives a direct blow or a jolt to their head that disrupts the function of the brain. Service members may sustain concussions or TBIs when exposed to a blast or explosion (sometimes on multiple occasions), which may lead to serious symptoms. There are three different levels of TBI (mild, moderate, and severe) based on the severity of damage to the brain.

PTSD is an anxiety disorder or condition that may develop after someone has experienced or witnessed a life-threatening or traumatic event, which may include a combat event. PTSD usually begins immediately after the traumatic event but it could start later, even years later. A PTSD event likely involved actual or perceived death or serious injury and caused an intense emotional reaction of fear, hopelessness, or horror.

Virtual Behavioral Health is a Western Regional Medical Command initiative that enables medical providers to conduct behavioral health screening remotely with Soldiers by use of video conferencing. This allows behavioral health assets in the region to maintain continuity of

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<sup>18</sup> According to an official from the U.S. Army WTC, the following definition applies to Warriors in Transition: “Combat Wounded” – Soldiers who have been wounded by enemy actions while serving in a contingency theatre of operations.

<sup>19</sup> A non-battle injury is defined as a person who becomes a casualty due to circumstances not directly attributable to hostile action or terrorist activity; also called NBI.

<sup>20</sup> The definition of PTSD is from multiple sources, including “Force Health Protection and Readiness Quick TBI and PTSD Facts,” October 15, 2008; and Jessica Hamblen, PhD, “What is PTSD?” National Center for PTSD, U.S. Department of Veterans Affairs, October 15, 2008.

<sup>21</sup> The definition of TBI is from multiple sources, including “Types of Brain Injury,” Brain Injury Association of America, October 15, 2008; and “Force Health Protection and Readiness Quick TBI and PTSD Facts,” Force Health Protection and Readiness, October 15, 2008.

care with Soldiers and family members during their redeployment cycle, while providing a “surge” capability for behavioral health screening that minimizes travel time and cost.

JBLM has a state-of-the-art Mild Traumatic Brain Injury (mTBI) clinic located on post within a mile of MAMC and the new WTB Complex. The mTBI Clinic consists of an interdisciplinary team, to include, but are not limited to: primary care providers, Neurologists, Neuropsychologists, Clinical Psychologists, Licensed Practical Nurse (LPN), TBI Case Managers, Education Specialist, Ombudsman, and Administrative Medical Assistants offering a variety of services to support Soldiers, and working together to provide quality medical treatment and education to Soldiers. During our interview, the mTBI Program Director indicated they had a collaborative relationship with the WTB staff in supporting Soldiers.

MAMC offers behavioral health services to include inpatient and outpatient psychiatric care, evaluation and management of psychotropic medications, individual and group psychotherapy, diagnostic evaluation and testing, and neuropsychological services. Soldiers may self-refer for mental health services to the Behavioral Health Clinic, which is operated as an open access walk-in clinic. Additional programs and services included:

- Substance Abuse Rehabilitation Program, Outpatient Counseling, Intensive Short-Term Outpatient program, PTSD Clinical Group;
- Preventive Intervention Program, to include, Stress and Anger Management; and
- Social Work Services and Service Dog program.

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## **Part I - Noteworthy Practices**

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## **Observation A. Noteworthy Practices for Joint Base Lewis-McChord Warrior Transition Battalion**

At the time of our assessment, we observed three noteworthy practices that Joint Base Lewis-McChord Warrior Transition Battalion had instituted with respect to providing quality services for Soldiers. Those practices included:

**A.1.** Availability of Resources to Assist Soldiers with their Transition to Civilian Life

**A.2.** Implementation of the Comprehensive Transition Plan Scrimmage

**A.3.** Co-Location of Social Workers at the Warrior Transition Battalion

Based on our assessment, we concluded that these three practices will continue to improve and enhance the recovery process for Soldiers and their transition from the Joint Base Lewis-McChord WTB.

## **A.1. Availability of Resources to Assist Soldiers with their Transition to Civilian Life**

Soldiers assigned or attached to the Warrior Transition Battalion were required to “in-process” through the Soldier and Family Assistance Center (SFAC) to ensure that they received a comprehensive orientation on the services available to them and their families. This comprehensive knowledge of available resources can greatly assist with easing the stress of and smoothing the transition for Soldiers and their families.

### **A.1. Background**

The SFAC is a component of the total continuum of Soldier care that provided integrated support services for Soldiers and their families at a “one-stop” location near the WTB. The JBLM SFAC provided crucial, non-medical services necessary to smooth the transition for Soldiers and their families assigned to the WTB and the Community Based Warrior Transition Unit (CBWTU) in California. Furthermore, services were available for non-WTB Soldiers who were going through the Medical and Physical Evaluation Board (MEB/PEB)<sup>22</sup> process and for any other military personnel and their families that came in requesting resources and services.

The SFAC services available to Soldiers and their families included:

- Information and Referral – assisted with Permanent Change of Station relocation services (e.g. household property, housing referral, newcomers)
- Financial Readiness and Educational Services – offered financial and educational assistance (e.g. spending plan, debt reduction, tuition assistance, scholarship options and VA educational benefits)
- Outreach and Veterans Services – links military and civilian support services with the SFAC; and assisted Wounded Soldiers with their transition to civilian life
- Child, Youth, and School Services (CYSS) – provided reduced childcare rates on and off post while Soldiers are assigned to the WTB
- Military Personnel Services – human resources assistance in updating Soldiers personnel records, tracking down orders, and awards
- Army Career and Alumni Program (ACAP), and Recovery Employment and Assistance Lifeline (REALifelines) – performed individual counseling session to develop an Individualized Transition Plan (ITP) for the Soldier; and offered assistance regarding employment opportunities based on career interests/or assessment tools
- Traumatic Servicemember’s Group Life Insurance (TSGLI) – an advocate was assigned to work with Soldiers in the WTB on filing claims based on traumatic injuries incurred
- Social Services/Social Security Assistance - conducted confidential family assessment and coordinated referral services for marital and family advocacy issues

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<sup>22</sup> Medical Evaluation Board (MEB) is the DoD process designed to determine whether a Soldier’s long-term medical condition enables him/her to continue to meet medical retention standards. The MEB is considered an informal board process because, by itself, it does not drive any personnel actions. The Physical Evaluation Board (PEB) formally determines fitness for continued service and eligibility for disability compensation.

## **A.1. Discussion**

The JBLM Warrior Transition Battalion Handbook “Phoenix Battalion,” March 2012, established guidance that each Soldier within 10 duty days of being assigned/attached to the WTB will “in-process” through the SFAC and complete a needs-based assessment with the Information and Referral (I&R) Coordinator. Upon completion of the assessment, the I&R Coordinator makes appropriate referrals for services within the SFAC to ensure the Soldier’s immediate individual and/or family needs are met.

The SFAC Director explained that designated staff was assigned to work one-on-one with National Guard and Reserve Soldiers on issues specific to their individual component. The staff also coordinated with the Guard and Reserve Centers on base to get Soldiers additional resources as needed.

Soldiers and medical/ non-medical support staff conveyed positive comments towards the SFAC services and resources. Specifically, they mentioned that the SFAC staff was “amazing,” and “awesome,” they always “find the answers to your questions,” and they “offer everything anyone would need.”

Despite the proximity of the SFAC to the WTB, we also were informed that some Soldiers were not aware of its programs and/or benefits, and did not take full advantage of the resources that were available to them.

## **A.1. Conclusion**

The SFAC served as the centralized resource for educating Soldiers and their Families or Caregivers on the variety of services available to assist them in their recovery and transition process. The JBLM WTB requirement for Soldiers to process through the SFAC appeared to have a positive impact for those Soldiers and Families who utilized the services. Additionally, we recommend that the U.S. Army Installation Management Command continue to fully support SFAC services and assistance to Soldiers and their families as they transition back to duty or civilian life. Finally, the WTB should continue efforts to increase Soldiers’ awareness of the multiple SFAC and other resources and assistance available to them.

## **A.2. Implementation of the Comprehensive Transition Plan Scrimmage**

Soldiers met regularly with the assigned Triad of Care team members and other support staff to discuss the individual Soldier's potential for further progress and identified concerns that could adversely affect their recovery and transition. As a result, Soldiers and the Triad of Care team members were able to develop an individualized course of action to address each Soldier's recovery needs and better facilitate his or her transition as part of the Soldiers Comprehensive Transition Plan.

### **A.2. Background**

According to the U.S. Army Medical Command Policy Guidance 09-011, "Comprehensive Transition Plan (CTP) Policy," March 10, 2009, all Soldiers assigned or attached to a WTU will begin their comprehensive transition plan within the first 30 days of assignment. The plan focused on the Soldier's future and included all applicable dimensions of a Soldier's life: health, profession, military, education, personal, spiritual and family. The plan was the Soldier's plan; it did not belong to the chain of command or the health care providers. Soldiers were accountable for meeting their goals; chain of command and healthcare providers would provide the support and counseling to assist the Soldier.

Subsequent to our visit, Warrior Transition Command implemented new guidance related to the Comprehensive Transition Plan (CTP), "Comprehensive Transition Plan Policy and CTP Guidance (CTP-G)," December 1, 2011. In addition, U.S. Army Medical Command Policy Guidance 11-098, "Comprehensive Transition Plan (CTP) Policy" was updated to formalize the review process that facilitates the Soldier's progression through the WTU/CBWTU.

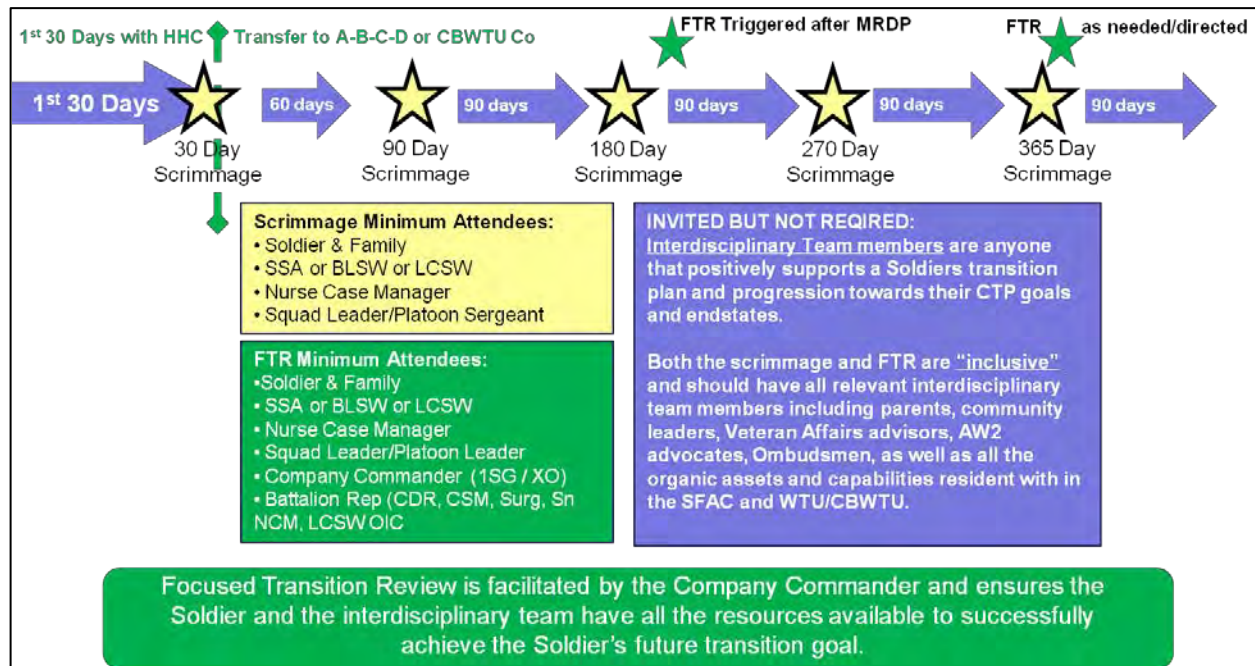
The new CTP-G established baseline standards for executing the CTP and defined roles and responsibilities for the WTB leadership, Triad of Care, and the interdisciplinary team. It also standardized processes and procedures for execution of the CTP, and described the CTP as a dynamic living plan of action that focuses on the Soldier's future, that is holistic, and encompassed the six domains of strength: career, physical, emotional, social, family, and spiritual. The Soldier, as the owner of the CTP, was empowered to take charge of his or her own transition and was accountable for developing and achieving his or her goals.

The CTP scrimmage is a formal meeting with the Soldier's interdisciplinary team that uses the six domains of strength to develop and refine a future oriented transition plan. Follow on scrimmages are designed to engage the Soldier in finalizing identified sub-goals and supporting action statements for their time in the WTU/CBWTU and the future. Subsequent scrimmages are executed every 90 days. (See Appendix E, for additional steps in the CTP process)

The minimum required attendees at the scrimmage were the Soldier, Squad leader/Platoon Sergeant, Nurse Case Manager (NCM), and the Licensed Clinical Social Worker (LCSW). Other staff may be invited to attend to support the Soldier, such as Occupational/Physical Therapy, Primary Care Manager, and SFAC representatives. Families were invited and encouraged to attend.

The CTP was designed to allow each Soldier to customize his or her recovery process, which enabled them to set and reach their personal goals with the support and guidance of the interdisciplinary team. The Soldiers' needs would drive the makeup of the interdisciplinary team of clinical providers and non-clinical leaders/supporters who played a positive and active role in the Soldier's transition plan. Ultimately the Soldier was responsible for the success of the Transition Plan. The Scrimmage and Transition Review Timeline is shown in Figure 4.

**Figure 4. Transition Review Timeline and Scrimmage**



Source: Warrior Transition Command, Comprehensive Transition Plan Policy and Guidance – December 1, 2011

## A.2. Discussion

During our visit to JBLM, the team observed a scrimmage where all members of the Soldier's interdisciplinary team were present, to include the Soldier. The LCSW led the scrimmage and also documented the Soldier's action plan based on the six domains. Dialogue was constructive among all attendees, and the Soldier was an active participant in discussion of his or her individual goals and activities, and identified areas where assistance might be needed. The NCM was especially familiar with all aspects of the Soldier's medical treatment needs. Information was also captured electronically by the squad leader who would finalize and review the action plan again with the Soldier prior to signing.

Many of the Soldiers we interviewed had positive things to say about their involvement in the CTP Scrimmage process. Their statements included:

- The process was good; it forced you to lay everything out and made you look hard at yourself. It also "simplified everything," kept you on track, and helped you prioritize.
- It was beneficial, and as a result of the reviews, things actually got done with regard to my medical needs.

- “It brings all the people I need together...it blends the WTB/discipline side with the medical side...It sets goals for the short-term, mid-term and long-term and gives me the “big picture” which I am not able to figure out myself.” “You can set the goal but if you are not motivated it is a senseless process and does not force you to do anything.”
- One National Guard Soldier stated that overall the processes are goal oriented for the Soldiers. He said, “The idea of setting goals as your end-state works well because it is your plan so you have something to strive for.” He mentioned that his new squad leader actually sits and reviews the CTP, makes notes, and addresses his issues with him.

The Company Commander conveyed that the process for the CTP was a living, breathing document and could be adjusted as needed. Additionally, another senior WTB official explained that the CTP was a valuable tool, offering focus for the Soldier. He further stated that a lot of the Soldiers are young and lack “life experiences” to guide them. The CTP forces Soldiers to look forward at the short/long term goals. The senior leader further explained that “if Soldiers don’t succeed at the WTB, they are at fault,” because there are so many opportunities for them with activities, jobs and school.

## **A.2. Conclusion**

The Comprehensive Transition Plan, while mandatory for all Soldiers upon entrance to the WTB, served as a living document for Soldiers as they began to identify and develop individual goals and resources needed for their recovery and transition. Additionally, the Comprehensive Transition Plan Scrimmage used by the WTB was an interdisciplinary team process that focused on the six domains of strength, and was designed to engage the Soldier in identifying goals for their time in the WTB and the future.

This noteworthy practice appeared to be well established within the JBLM WTB in providing an interdisciplinary approach to meeting Soldier’s transition goals and needs. We believe that the Warrior Transition Command should periodically evaluate the policy guidance and practices related to the Comprehensive Transition Plan to ensure ongoing effectiveness throughout the Army Warrior Transition Command.



### **A.3. Co-Location of Social Workers at the Warrior Transition Battalion**

Social Workers' offices were co-located at the Warrior Transition Battalion headquarters and barracks where Soldiers reside. As a result, Social Workers were readily accessible to the Soldiers they were assigned to for evaluation and therapy. Furthermore, the accessibility of the Social Workers provided a direct interface with the Soldiers and established a solid support system to enhance and support the Soldier's recovery and transition.

#### **A.3. Background**

The Office of the Surgeon General Medical Command Policy Memo, 10-047, "Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy," July 13, 2010, states that all Warriors in Transition (WT) will receive a BH risk assessment within 24 hours of attachment or assignment to a WTU and that ongoing BH risk assessment and care management will be a standard of WT care.

Additionally, the policy required the WTB Clinical Social Worker to conduct the comprehensive BH assessment, ongoing BH risk assessment, care management, and support to the Family/Caregivers regarding behavioral health. According to the current Comprehensive Transition Plan Policy and Guidance, CTP-G, December 1, 2011, the Licensed Clinical Social Worker (LCSW) was defined as the behavioral health expert and consultant to the command.

#### **A.3. Discussion**

This was the first WTB the team observed at which LCSWs were embedded in the WTB performing as the primary mental health providers for the Soldiers. LCSWs were aligned to one of four WTB companies, and were physically located in the WTB where Soldiers reside. Based on previous site assessments, the team identified the co-location of LCSWs within the JBLM WTB companies as a "Best Practice."

A lead LCSW was assigned to each WTB company to evenly distribute workload and also to provide coverage for the Company. Additionally, the LCSWs stated that the co-location was effective from a safety standpoint and for meeting mandatory training requirements. One LCSW provided an example where a Soldier called the hotline, and within minutes everyone was working together to best meet the immediate needs of the Soldier.

The LCSWs were available 24/7 for the Soldiers, and they were also responsible for seeing all patients who arrived by medical evacuation<sup>23</sup> to JBLM and for conducting Suicide Risk Assessments. One LCSW explained that within 5 days of the Soldiers arrival they were required to complete a full psychosocial workup on the Soldier. Furthermore, within the first 30 days they held the Soldiers' initial CTP Scrimmage where the team met with each Soldier to develop their individual treatment plans.

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<sup>23</sup> Medical evacuation is defined as transporting a patient to a place where medical care is available.

In addition, the LCSWs were involved in direct therapy, group therapy and referrals, and were also engaged in the spouse PTSD support group. Not only did they support the Soldiers and Families, they also attended Company meetings, Triad of Care and High Risk meetings, and resiliency care conferences in addition to providing support to the Battalion staff.

### ***A.3. Conclusion***

Alignment of the LCSWs within the WTB companies as primary mental health providers was an effective practice and a model that worked well at the JBLM WTB. This practice promoted collaboration among the interdisciplinary team members, enhanced communications, and ensured safety as the Soldier progressed through the healing, recovery and transition process. As outlined in the recently published CTP guidance, the LCSW was instrumental in providing support and addressing the social and behavioral health needs for the Soldiers and their families. The Warrior Transition Command should continue to promote having LCSWs embedded in the WTB, physically proximate and closely coordinated with NCMs and other WTU staff, where feasible.

## **Observation B. Noteworthy Practice for Madigan Army Medical Center – Madigan Healthcare System**

At the time of our assessment, we observed a noteworthy practice that Madigan Army Medical Center had instituted with respect to providing quality services for Soldiers. That practice included:

### **B.1. Equal Access to Care**

We believe this practice has already shown benefits and will continue to improve and enhance the recovery process for Soldiers and their transition from the Joint Base Lewis-McChord WTB.

## **B.1. Equal Access to Care**

Based on our interviews with JBLM WTB Soldiers and WTB support staff we determined that there was no difference in access to medical care for Active and Reserve Component Soldiers at Madigan Army Medical Center.

### ***B.1. Background***

In May 2010, Senator Ron Wyden and Congressman Kurt Schrader both of Oregon requested that we investigate medical treatment entitlements for all Guard and Reserve Soldiers at all Warrior Transition Units and mobilization and demobilization sites. As part of our ongoing assessment project, the DoD IG remained focused on the concerns regarding the management of Reserve Component (RC)<sup>24</sup> Soldiers in the Warrior Transition Units (WTUs).

At the time of our site visit there were 451 Soldiers assigned or attached to the WTB at JBLM; 207 Active Duty, 168 National Guard, and 76 Reservists. Between June 2007 and December 31, 2012, a total of 2,697 Soldiers had transitioned through the JBLM WTB; 1,482 Active Duty, 826 National Guard, and 389 Reserve Soldiers.

### ***B.1. Discussion***

We interviewed 26 Active Duty, 27 National Guard, and 7 Reserve Soldiers who were assigned or attached to the JBLM WTB. One National Guard Soldier commented that “no one knows the difference between Active and Guard....unless you tell them – they are all Wounded Warriors and should be treated the same.” Several other Soldiers commented that there was no noted difference in treatment of Active versus Guard/Reserve or combat wounded versus non-combat wounded.

During several individual Soldier interviews, one Soldier stated they should be treated the same regardless of component or how the injury occurred. A different Soldier stated that the WTB has priority over everyone, and felt that differences should depend on the Soldier’s needs, and the worst should have the preferences. Lastly, one Soldier commented that they get equal access to care, but it is a question as to whether the Warriors use it to their benefit.

A WTB primary care provider explained that there were no differences in access or medical treatment between Active, Guard and Reserve Soldiers among the WTB providers, or hospital staff, and that most staff do not ask Soldiers which component they belong to.

Finally, the group of social workers that we interviewed all agreed that all Soldiers in the WTB were getting good medical and behavioral health care. One social worker noted that about seventy percent of the Soldiers they see had behavioral health issues, which was their primary focus.

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<sup>24</sup> The Army consists of two distinct and equally important components, the Active Component and the Reserve Component (Army National Guard and the Army Reserve).

Subsequent to our site visit to the WTB at JBLM, we met with the National Guard Bureau Chief Surgeon on November 15, 2012 and the Oregon National Guard Joint Forces Headquarters on November 28, 2012. During these meetings, they expressed no concerns about the management of Guard and Reserve Soldiers with respect to their access to WTU resources.

### ***B.1. Conclusion***

Overall, the Soldiers interviewed stated they received equitable access to medical care for the condition(s) that required their assignment or attachment to the WTB. Furthermore, the medical and administrative personnel supporting the WTB indicated equitable access to medical care was provided to Active and RC Soldiers.

Based on our assessment, we concluded that Active Duty and RC Soldiers had received equal access to medical care while assigned to the WTB at JBLM.

We recommend continuing analysis of patient satisfaction surveys in order to detect problems, if any, and appropriately address them as they occur.

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## **Part II - Challenges**

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## **Observation C. Challenges for Joint Base Lewis-McChord Warrior Transition Battalion**

We identified four challenges that should be addressed by the Battalion's leadership and staff to ensure the most successful and effective support for the care, healing, and transition of wounded, ill, and injured Soldiers. These challenges are identified as follows:

**C.1.** Staff Training in Support of Soldier Recovery and Transition

**C.2.** Staffing and Change of Station Requirements for Warrior Transition Battalion Leadership

**C.3.** Comprehensive Transition Plans

**C.4.** Soldiers' Education, Employment and Internships

We believe that improvements in addressing these challenges will increase the effectiveness of the JBLM Warrior Transition Battalion leadership and staff performance in providing quality and timely care and services that facilitate Soldier recovery and transition.

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## **C.1. Staff Training in Support of Soldier Recovery and Transition**

Personnel involved in the management of WTB Soldiers did not consistently receive training prior to assuming WTB cadre duties. Additionally, cadre who had received the training offered believed they needed additional training to address the diverse range of Soldiers' medical and management needs.

Some newly assigned WTB cadre did not receive training prior to or soon after arrival to the WTB for a number of reasons, one of which included the slow administrative processing time to approve Guard and Reserve positions. In addition, the current training programs did not provide sufficient in-depth information to help them deal with the full range of medical and management needs of their assigned Soldiers.

As a result, WTB personnel working with the Soldiers were at risk of not having the requisite knowledge and capability to effectively assist the Soldiers and their families in their healing and transition process.

### **C.1. Background**

Those responsible for the medical care and management of Soldiers were required to complete online and resident courses. Operational Order (OPORD) 07-055, "Implementation of the Army Medical Action Plan (AMAP)," <sup>25</sup> June 2007, established the development and delivery of standardized training for the staff of Warrior Transition Units with special focus on the "WTU Triad." Distributed learning modules were developed and deployed for training in August 2007, followed by resident courses in October 2008.

WTB staff were required to attend a 2-week (10-day) course designed to provide standardized training for newly assigned staff to a WTB. Common Core courses included, but were not limited to:

- Comprehensive Transition Planning and Risk Assessment and Tools
- Overview of Medical and Physical Disability System
- Personnel Assignments and Utilization
- Personnel Actions Overview, and IG issues/concerns
- Life Coaching Skills, Psychology of Injury, Suicide Prevention
- Medical Terminology, Psychotropic Medications, PTSD for non-medical personnel.

### **C.1. Discussion**

The WTB staff played a pivotal role in assisting Soldiers with their healing and transition. Thus, it was imperative that the training and support provided to the staff was comprehensive,

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<sup>25</sup> The Army Medical Action Plan (AMAP) establishes an integrated and comprehensive continuum of care and services for Warriors in Transition. The AMAP was developed in 2007, and included ten "Quick Wins" for implementation across the Army. Item six identifies development of training and doctrine.

informative and timely. JBLM WTB staff suggested several areas and topics where training could be improved, to include:

- “Training should take place before taking on WTU responsibilities”
- “Course could be longer and include more behavioral health, role playing scenarios, and how to communicate effectively through counseling sessions with Soldiers”
- “Training on command and control and medical management issues and what each of the separate entities do”
- “Training on specific Guard and Reserve administrative requirements”
- “Stress reduction for staff”
- “Team training exercises”

Several squad leaders stated that the two-week training was adequate. However, one squad leader explained that they should be trained prior to taking on any responsibilities involving the direct management of WTB Soldiers.

Another squad leader commented that he shadowed another squad leader for about 2 months and felt it was informative and helpful. He further commented that the 2-week course needed to be more in-depth and longer because each of his Soldiers had a different issue and it was all “trial by fire” in learning how to deal with them. This particular squad leader explained that he felt his position was one of the most challenging jobs in the Army, noting that in a regular unit, “you might have one or two out of 40 guys with complex issues; here, all 15 have some issue.”

Several individual Soldiers commented on the cadre training. One Soldier commented that the cadre should be trained before they come. Another Soldier mentioned that turnover of staff was quick. He further explained that those cadre not trained early on were not as prepared to provide direction to the Soldiers.

The WTB senior leadership explained that not all WTB cadre and staff received the two week training prior to assuming duties in the WTB, and some did not receive training until six months (or after one quarter of their two-year tour had been completed) after their arrival. The leadership commented that the process to source Guard and Reserve personnel was through the Department of the Army Mobilization Processing System,<sup>26</sup> which was slow and did not allow tour overlaps or “right seat/back seat” training opportunities.

WTB leadership commented that an estimated sixty percent of the Soldiers assigned to the JBLM WTB had behavioral health issues, with an estimated forty percent of the Soldiers having PTSD or TBI. Given the prevalence of these conditions, WTB leadership and staff recognized the need for additional PTSD/TBI and behavioral health training opportunities. Specifically, they recommended:

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<sup>26</sup> Department of the Army Mobilization Processing System – Army (DAMPS-A) is an unclassified web application to initiate, track, and approve reserve component (RC) volunteer packet requests for contingency active duty for operational support (CO-ADOS) tours.

- “Training in behavioral health disorders to include PTSD, muscular-skeletal conditions, and appropriate pain management associated practices.”
- “Focused training needs for staff in areas such as Anger Response Training, Non-violent crisis intervention training, and safety training in regards to deescalating a situation.”
- “Offer a Behavioral Health 101 for primary care managers (PCM), nurse case managers (NCM), and squad leaders to address fears and concerns about some of the varied types of behavioral health issues encountered; address Soldiers’ medications, their side effects and the potential for unusual reactions that could occur when taking certain medications.”
- Staff Resiliency training: several Platoon Sergeants mentioned that they would be attending the Master Resiliency Training Course in Philadelphia and would provide “train-the trainer” for other staff in the WTB.

A senior NCM acknowledged the need for additional training in dealing with PTSD/TBI and Behavioral Health patients, but noted that “you are still never prepared for some of the types of issues these Soldiers have.” She referred to an experience in which a Soldier became out of control, stating you “just have to pull from life experiences” as you handle those types of Soldiers; there is no real way to be prepared because they are all different.

### **C.1. Conclusion**

Appropriate and timely training for WTB staff is required to ensure the most effective and efficient management and support of the Soldiers’ mission to heal and transition. Therefore, attending training prior to, or in route to their assignment at the WTB would ensure staff had the appropriate tools to be successful in managing and providing support to Soldiers under their supervision.

While a relatively comprehensive training program does exist for WTB leadership and NCMs, it is important to ensure that the program provides curricula to address specific behavioral health and other issue areas important to perform Soldier support needs. Classes should reflect realistic scenarios and facilitate discussion regarding Soldier care and management within the WTB environment.

### **C.1. Recommendations, Management Comments, and Our Response**

**C.1.1. Commander, Human Resources Command in coordination with the Commander, Warrior Transition Command develop policy guidance to direct Active and Reserve Component Soldiers who volunteer for WTB leadership and cadre positions to attend WTB cadre and staff training prior to, or in route, to their assignment at the WTB.**

### **Office of the Surgeon General, U.S. Army Medical Command Response**

The Office of the Surgeon General, U.S. Army Medical Command concurred with comment to our recommendation. The Commander, Human Resources Command issued MILPER Message

12-006, Warrior Transition Unit (WTU) Cadre Assignments, on 9 January 2012 requiring approved cadre to attend the WTU Cadre Resident Course enroute to assignment whenever possible. When not feasible to attend the course enroute, attendance will be completed 90 days of assuming a cadre position.

### ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Commander, Warrior Transition Command provide a copy of the WTC MILPER Message 12-006, Warrior Transition Unit (WTU) Cadre Assignment.

**C.1.2. Commander, United States Army Medical Department Center and School in coordination with the Commander, Warrior Transition Command, evaluate the effectiveness of the WTB leadership and cadre training program to ensure that the course for cadre includes a robust training curriculum and ongoing educational training opportunities. Also, to ensure that the Triad of Care team members and WTB support staff are appropriately prepared to deal with the unique mission challenges of helping Soldiers to recover, and transition back to active duty or return to civilian life.**

### ***Office of the Surgeon General, U.S. Army Medical Command Response***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comment to our recommendation. The Surgeon General reported that the U.S. Army Medical Department Center and School continually evaluates the effectiveness of the WTB leadership and cadre training program through the use of end-of-course surveys, curriculum reviews, and informal collaboration with the Warrior Transition Command (WTC). In addition, several other program tools are in development and projected for implementation over the next several years. The Surgeon General stated that in FY12, MEDCOM completed a manpower review and analysis which highlighted the requirement for increased manpower based on the large instructor-to-student ratios and the lack of an Army-approved Table of Distribution and Allowances (TDA). The U.S. Army Medical Department Center and School is awaiting approval for authorization and increased manpower from U.S. Army Manpower Analysis Agency.

### ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Commander, U.S. Army Medical Department Center and School upon approval by the U.S. Army Manpower Analysis Agency provide a copy of the new manpower authorization.

Additionally, we request that the Commander, U.S. Army Medical Department Center and School provide an update on the impact of proposed staffing levels and reduced instructor-to-student ratios; analysis of findings from curriculum review; post-graduate survey development and status of the distributed learning orientation course implementation. Furthermore, provide

an update of any further course work that is in development or being implemented based on ongoing internal reviews.

Finally, in response to our final report, we request that the Commander, Warrior Transition Command provide a synopsis of the effectiveness of adding civilian Transition Coordinators (TC) in each of 17 WTBs to support employment, education, and internship program opportunities for Soldiers.

## **C.2. Staffing and Change of Station Requirements for Warrior Transition Battalion Leadership**

Implementation of recent Army policy changes may adversely impact the number and predictability of WTB personnel serving to support Soldiers assigned or attached to the WTB. This policy directs that Reserve Component Soldiers who volunteer for WTB leadership positions shift from temporary to permanent change of station status.

The financial savings from this assignments policy change will largely be borne by Reserve Component volunteers, and may reduce the numbers of Reserve Component personnel who volunteer for WTB positions.

This may lead to insufficient numbers and predictability of Reserve Component personnel to provide effective management support for the care and healing of WTB Soldiers in transition.

### ***C.2. Background***

Reserve Component (RC) Soldiers serving in WTB cadre or leadership positions were assigned under the All Army Activities (ALARACT),<sup>27</sup> 053-2008, “Authority for Issuing Temporary Change of Station (TCS)/Temporary Duty (TDY) Orders beyond 180 Days in Support of Contingency Operations.”

“Department of the Army Personnel Policy Guidance for Overseas Contingency Operations,” July 1, 2009 outlines the assignments process for RC Soldiers who desire to serve beyond their 24 consecutive months of mobilization, to include volunteer positions, under the authority of Title 10 USC 12301(d), Contingency Operations Active Duty for Operational Support (CO-ADOS). In addition, ALARACT 210/2009, “Warrior Transition Unit (WTU) Personnel Assignment and Utilization Policy,” July 2009, provides guidance to Personnel and senior Commanders for nomination, selection approval, and assignment of cadre members.

### ***C.2. Discussion***

At the time of our assessment,\* the JBLM WTB population consisted of 451 wounded, ill, or injured Soldiers. The majority of WTB cadre and leadership positions were filled by Officer and Enlisted Active and RC Soldiers who volunteered to serve as cadre for one year providing leadership and direction to wounded, ill, and injured Soldiers. Table 2 illustrates the assigned/authorized WTB staff as of June 2011.

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<sup>27</sup> ALARACT is an acronym for All Army Activities (Distribution)

\* See Appendix A of this report



**Table 2. Assigned/Authorized WTB Staff as of June 2011**

June 2011	Authorized	Assigned
<b>Active</b>	60	61
<b>Guard</b>	29	21
<b>Reserve</b>	26	23

*Source: Data provided by JBLM Warrior Transition Battalion, November and December 2012.*

The RC Soldiers were selected for assignment to the WTB on a temporary duty status, normally for one year with the option to apply for an extension based on the Commander's discretion and the availability of CO-ADOS funds for RC Soldiers eligibility. Additionally, most, if not all RC Soldiers lived in other states, temporarily leaving their families and jobs to volunteer for the WTB staff positions.

Team interviews with WTB leadership revealed that the recent Permanent Change of Station/Temporary Change of Station (PCS/TCS) policy change could adversely impact the recruitment and predictability of RC Soldiers to fill staff positions within the WTB. Furthermore, if a funding solution is not permanent or constant, then RC Soldiers may not continue to volunteer for WTB positions.

Subsequent to our visit, the Department of the Army issued Executive Order, 079-13, "Warrior Care and Transition Program (WCTP) CO-ADOS, Exemption Approval and 730-Day CO-ADOS Order Implementation Guidance." The Executive Order approved a full exemption of the WCTP CO-ADOS requirements for Warrior care cadre and staff, and approved the use of 730-day CO-ADOS orders in an effort to assist in recruitment of RC Soldiers and minimize cadre turnover.

## **C.2. Conclusion**

Changes in Army policy requiring RC Soldiers to PCS when accepting WTB cadre or leadership positions had the potential to not only impact the number of RC Soldiers volunteering for WTB positions, but could also affect the predictability of the candidate pool. The WTB was dependent upon a number of RC Soldiers to volunteer for a variety of leadership positions within the WTB.

Without proper planning and oversight of future WTB staffing, there is the potential for gaps in WTB leadership positions that could have a negative impact on the care, management, and transition of Soldiers assigned or attached to WTBs.

## **C.2. Recommendations, Management Comments, and Our Response**

### **C.2.1. The Assistant Secretary of the Army, Manpower and Reserve Affairs in coordination with the Commander, Warrior Transition Command:**

**C.2.1.a. Evaluate current and future manning requirements of Warrior Transition Units to ensure they are appropriately staffed to meet the mission and have experienced cadre in place to effectively manage and support Soldiers during their healing and transition.**

## ***Office of the Surgeon General, U.S. Army Medical Command Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comment to our recommendation. The Surgeon General reported that the Warrior Transition Command conducts periodic reviews of Warrior Transition Unit (WTU) Table of Distribution and Allowance (TDA). The Surgeon General further explained that WTUs are structured based on forecasted Warrior in Transition (WT) population. The forecast models Pre-Deployment, Theater Evacuation, and Post-Deployment gains into the WTU population while accounting for actual deployment schedules into the future. Additionally, this forecast process ensures WTUs are adequately designed to support WT population increases on installations, and adjust manpower to those installations where WT populations are trending downward.

The Surgeon General stated that the Warrior Transition Command received approval to continue to fill Contingency Operation for Active Duty Operational Support positions as required, and use 2-year permanent change of station orders instead of 1-year orders. Finally, they reported that the Warrior Transition Command is in the process of revising the cadre assignment policy to ensure best-qualified personnel are selected.

## ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Commander, Warrior Transition Command provide a copy of the revised signed policy on WTU cadre assignments.

**C.2.1.b. Conduct an analysis to determine if Warrior Transition Units/Warrior Transition Battalions have adequate personnel resources and funding to support appropriate manpower levels, ongoing staff training requirements, and support services in order to maintain optimal staffing levels and ratios.**

## ***Office of the Surgeon General, U.S. Army Medical Command Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comment to our recommendation. The Surgeon General reported that in December 2012, the US Army Manpower Analysis Agency (USAMAA) validated the WTU Ratio Determination Model for use in determining manpower requirements for all WTUs and Community Care Units. In addition, they reported that USAMAA approved the model application for 3 years. The Surgeon General further explained that based on the significant decrease in supplemental funding now through FY15, funding for Reserve Component Soldiers remains an issue. Furthermore, Warrior Transition Command has requested that the Department of the Army consider an alternate sourcing solution to continue required Reserve Component support.

## ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Commander, Warrior Transition Command provide an update on the Department of the Army's alternate sourcing solution response to address the requirement for continued Reserve Component Soldiers support in WTUs.

### **C.3. Comprehensive Transition Plans**

Some Soldiers and Triad of Care members were not using the Comprehensive Transition Plan (CTP) in a manner that was consistent with the standards required by Army policy as the planning tool necessary to support successful recovery and transition goals of Soldiers.

This occurred because some Soldiers were not taking advantage of the benefits of the CTP. In some cases, Soldiers were not truthful or accurate with the information they provided to the CTP; feedback by some squad leaders was ineffective and untimely; and operation of the automated CTP on the Army Knowledge Online website was cumbersome, unreliable, and time consuming.

As a result, there were WTB Soldiers who were not receiving the full benefits of the CTP process as intended to help support their recovery and transition goals, thus delaying their transitions and putting at risk its success.

#### **C.3. Background**

The Office of the Surgeon General Medical Command Policy Memo, 09-011, "Comprehensive Transition Plan (CTP) Policy," March 10, 2009, stated that all Soldiers assigned or attached to a Warrior Transition Unit (WTU) will begin their comprehensive transition plans within 30 days of assignment. The policy also addressed the guidelines for developing the clinical and non-clinical plans of care which support the CTP.

According to the JBLM WTB Standard Operating Procedure, "Comprehensive Transition Plan," December 14, 2010, to facilitate the standardization, visibility, and overall effectiveness of the CTP, the Warrior Transition Command developed the CTP automation system within the Army Knowledge Online (AKO). The Army's Enterprise Portal, AKO is a primary component of the Army Knowledge Management (AKM) strategy and the Army Transformation. AKO provides corporate internet services and single web portal to the United States Army. AKO provides the U.S. Army with email, directory services, portal, single sign on, blogs, file storage, instant messenger, and chat.

The March 2011 CTP Policy provided interim guidance for the development and implementation of the Soldier's CTP and automated CTP (aCTP) documentation tool. It stated that the primary focus of the CTP was to provide a strategic tool that supported the Soldiers' goals to heal and successfully transition back to the force or to separate from the Army. Furthermore, the primary function of the WTU team was to assist in realistic goal development, provide support to the Soldier, and to validate the Soldiers' CTP. In addition, the guidance stated that Soldiers are encouraged to utilize WTU assets to assist them in advancing their current career or preparing for a career change, while undergoing medical treatment.

The Office of the Surgeon General Medical Command Policy Memo, 11-098, "Comprehensive Transition Plan (CTP) Policy," November 29, 2011, updated policy and formalized the CTP process for Soldiers assigned or attached to WTUs. The policy describes the CTP as a dynamic living plan of action that focuses on the Soldier's future. As owner of the CTP, the Soldier is empowered to take charge of his or her own transition and is ultimately accountable for developing and achieving his or her goals. Appendix E outlines the six processes of the CTP.

### **C.3. Discussion**

In Part 1, A.2., “Noteworthy Practices,” we recognized JBLM WTB for their implementation of the CTP Scrimmage. It is important to note, that during our site assessment, JBLM was piloting the CTP process which has since been fully implemented at all WTU/WTBs.

The automated CTP (aCTP) was an on-line assessment tool that a Soldier completed upon assignment or attachment to the WTB. This initial assessment was then reviewed by the squad leader and NCM to determine the needs of the individual Soldier. Completion of the aCTP by the Soldier was an ongoing process requiring weekly updates by the Soldier. Soldiers that we interviewed offered varying comments about their completion of the aCTP. Specifically:

- “We completed the CTP, but did not receive feedback from leadership.”
- “The online CTP was basically a waste of time, unless you wanted to be harassed.”
- “The automated CTP on AKO was “a joke.” Guys just “click” on things, if they knew someone was reading it, they might put forth a better effort.”
- “If the automated CTP was reviewed beyond what they put in, it would be a good tool.”
- “Weekly was too often; bi-weekly would be better.”
- “The AKO was slow and freezes up; was not good because of Information Technology issues.”
- “Received feedback once, but believed this was not the case with the majority of the Soldiers.”

WTB leadership commented that using the AKO portal to make required entries into the CTP was cumbersome and slow. Additionally, they explained that completing the CTP was time consuming and suggested that the frequency of completing the assessment should be changed from weekly to monthly. Additional comments shared by leadership included:

- One squad leader explained that he conducted monthly counseling and reviewed his Soldiers’ goals with them. He was aware that Warriors complained about filling the CTP out weekly, but he believed the CTP was beneficial because the squad leaders were also able to gain timely updates about their Warriors. He believed it was especially effective for the younger Soldiers, because “for some they needed the push.” He further commented that if you review the CTP with them and hold them to their goals, they actually accomplish things.
- Another squad leader explained that his Soldiers complete their CTPs online every week and he personally believed it was a waste of time. There were problems with AKO freezing or being slow and it took at least 10 minutes to load one Warrior’s CTP.
- The occupational therapists mentioned that the aCTP could be a better tool if they eliminated the redundancy, adjusted the updates to monthly versus weekly, and moved the automated CTP from the AKO platform to a more responsive system.

Although several of the comments made about the CTP were therefore negative, there were several other WTU staff members who commented that the CTP did have a positive effect on the

Soldiers' recovery and transition, if the Soldiers took the time to fill it out. They explained that functionally it was improving; however, as leaders, they wanted to have more control of the frequency of CTP updates based on the Soldiers' needs. Furthermore, the WTU leaders noted that effectiveness of the CTP is marginalized because "it is left up to the Soldier," there was a lack of incentives to accomplish set goals and no risk of adverse actions for failing to accomplish set goals.

### ***C.3. Conclusion***

The CTP is a tool that assists the Soldier and Triad of Care interdisciplinary team in providing the best direction for the Soldier's care and transition. The aCTP self-assessment tool was the first step in capturing the clinical and non-clinical plans of care. Although there were some positive comments made about the CTP, several Soldiers and WTB staff complained about the slowness of the AKO platform used to complete the aCTP. Additionally, Soldiers and staff also believed that weekly updates of the aCTP were unnecessary.

Since our visit, Warrior Transition Command (WTC) has completed an extensive review of the CTP process, requesting input from end users on how the plan and system could work better for them. Additionally, WTC has continued to improve the CTP automation and documentation capabilities necessary to manage the care and support of Soldiers.

Subsequent to our visit, the WTC formalized the "Comprehensive Transition Plan Policy and CTP-Guidance (CTP-G)," December 1, 2011. The guidance described that the automated CTP would move off the AKO platform to the Army Warrior Care and Transition System (AWCTS).<sup>28</sup> Within AWCTS, the automated CTP would continue to serve as the primary tool for the execution of the CTP and should play a critical role in the collection and assessment of Soldier CTP records across the WTC. This was not always the case, however.

### ***C.3. Recommendations, Management Comments, and Our Response***

#### **C.3.1. Commander, Warrior Transition Command:**

**C.3.1.a. Complete the migration of the Comprehensive Transition Plan from the Army Knowledge Online to the Army Warrior Care and Transition System.**

**C.3.1.b. Review the Comprehensive Transition Plan policy and guidance for relevance and effective content in supporting Soldier and Family transition needs.**

### ***Office of the Surgeon General, U.S. Army Medical Command Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comment to our recommendation. The Surgeon General stated that migration of the Comprehensive

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<sup>28</sup> Army Warrior Care and Transition System (AWCTS) is a web-based application hosted at Defense Information System Agency (DISA) and uses AKO for Common Access Card (CAC) authentication purposes. The system also has the capability to track each Soldier's progress.

Transition Plan (CTP) from Army Knowledge Online to the Army Warrior Care and Transition System (AWCTS) was completed in June 2012, in accordance with the timeline provided in Annex A to WTC OPORD 11-10. The AWCTS consolidates Warrior Care and Transition related information technology systems into a comprehensive system to manage wounded, ill, and injured Soldiers and their Families from point of injury to transition.

Additionally, Warrior Transition Command commented that they will review and update CTP policy and guidance by December 31, 2013. Lessons learned from the field and leaders will be incorporated to ensure Soldiers and Families receive the best transition assistance and care possible.

### ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Commander, Warrior Transition Command, provide an updated copy of the signed CTP policy and guidance, based on their December 2013 review.

**C.3.2. Commander, Warrior Transition Battalion, evaluate the effectiveness of the WTB leadership and cadre in actively engaging the Soldiers' CTP and encourage Soldiers' involvement and adherence to the plan for a successful transition.**

### ***Office of the Surgeon General, U.S. Army Medical Command Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comment to our recommendation. The Surgeon General stated that in order to ensure effective engagement in the Soldiers' CTP and encourage Soldiers' involvement and adherence for a successful transition, the CTP management analyst will provide weekly by name reports to the appropriate Company Commanders for each Soldier. The report includes those Soldiers exceeding 30 days without having Phase 1 Goal Setting completed and confirmed by the Commander via the Army Warrior Care and Transition System (AWCTS); Soldiers Self Assessments not completed in accordance with designated frequency, and Soldiers Self Assessments not validated by Nurse Case Managers and by the Platoon Sergeant/Squad Leader. In addition, the Surgeon General reported that Nurse Case Managers will sign and attach initial scrimmage worksheets to the Soldiers AWCTS file to serve as a record and facilitate TRIAD collaboration, and the Senior Nurse Case Manager will ensure compliance with monthly AWCTS reviews.

Finally, the Surgeon General stated that Warrior Transition Command will further evaluate effectiveness of WTB leadership through the Operational Inspection Program (IP) and command and staff visits.

### ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. No further action is required.

## **C.4. Soldiers' Education, Employment, and Internships Program**

Some WTB Soldiers were unable to participate in non-Federal employment and internship opportunities consistent with their transition goals.

Current DoD policy prohibited Soldiers from participating in non-Federal internship programs. DoD guidance did not reflect recent changes in Public Law that would allow Soldiers to participate in non-Federal internships.

As a result, Soldiers were not able to take advantage of state or local internships available which could significantly benefit their individual transition goals.

### **C.4. Background**

The Warrior Transition Command Policy Memo, 09-003, "Warrior in Transition (WT) – Employment, Education and Internship (EEI) Opportunities," October 15, 2009, described EEI as an integral part of a Soldier's healing and transition. These opportunities expand Soldier abilities, increase productivity, and orient the Soldier toward a productive and rewarding future. The policy guidance directed that WTs were restricted to Federal government internships while still on active duty. Moreover, DoDI, 1000.17, "Detail of DoD Personnel to Duty Outside the Department of Defense," April 16, 2008, placed limitations on details<sup>29</sup> for DoD personnel.

Subsequent to our visit, the Warrior Transition Command, released the CTP Policy and Guidance (CTP-G), December 1, 2011 which outlined that all medically ready soldiers will participate in adaptive reconditioning and Career and Education Readiness (CER) opportunities that support his or her CTP during rehabilitation and are within their physical profile guidelines. The CER has replaced the 2009 EEI opportunities guidance.

Several Federal programs for recovering service members were also available for Soldiers to participate in. These programs included, but were not limited to:

- Operation Warfighter (OWF), established by the Department of Defense in 2006, is a Federal internship program for wounded, ill, and injured service members. The main objective of OWF is to place service members in supportive work settings that positively impact their recuperation.
- VA Coming Home to Work (CHTW) Program is a Vocational Rehabilitation and Employment (VR&E's) primary early intervention and outreach program. The VR&E goal is to assist eligible servicemembers and veterans obtain and maintain suitable employment that will not aggravate disabilities.

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<sup>29</sup> Pursuant to the DoDI 1000.17, a detail is the "temporary assignment of a military member or DoD civilian employee to perform duties in an Agency outside the Department of Defense with the intent of returning to the Department of Defense upon completion of those details."



## **C.4. Discussion**

According to the “Comprehensive Transition Plan Guidance,” March 11, 2011, Soldiers are expected to participate in appropriate EEI Programs once they reach the rehabilitation phase of their transition.

During our visit to JBLM we were told that Soldiers who had been engaged in internships with state and local government agencies were required to relinquish them. Warrior Transition Command policy guidance directed that Soldiers were restricted to Federal government internships while still on active duty. This is in addition to the DoDI which also placed limitations on details of DoD personnel. Therefore, Soldiers could only be able to participate in Federal internship opportunities.

However, limiting internships to Federally-sponsored training opportunities directly affected Soldiers’ ability to participate in training activities related to his or her transition interests or needs. This caused numerous internship opportunities with state and local government entities to go unfilled and increased Soldiers’ frustration with the transition process. WTB leadership explained that the restriction to ‘Federal’ only internship programs greatly reduced the opportunities available to Soldiers and could potentially have an adverse impact on their healing and individual transition goals.

Staff working with Recovering Soldiers expressed concerns about limitations with respect to EEI opportunities. Specifically:

- A WTB staff member explained that “Soldiers did not want to pursue education and internships out of concern they would not have enough time to finish based on the requirements of MEB/PEB process.”
- The Soldier and Family Readiness Center (SFAC) Director pointed out those OWF internships with Federal agencies required security clearances which took time to complete. She also explained that these clearances needed to be expedited or changed to interim clearances so that Warriors who were eligible could work longer at these internships.
- Attempts were made for internships to be in line with the Soldier’s military occupational specialty<sup>30</sup> or something of professional interest that would be productive for the Soldier in their transition.

Several Soldiers expressed concern over the process for internship selections and the requirements for internship opportunities. Specifically:

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<sup>30</sup> The military occupational specialty (MOS) is a code used to identify jobs in the U.S. Army. The numbers correspond to the career field and the letter corresponds to a particular job in the career field.

- One Soldier stated that he was “thrown into an internship that he did not get to pick,” which he stated felt like punishment to him. He further commented that in order for him to feel productive in an internship, he should be placed in something that would correlate with what he wanted, which was to go to college to learn to be a mechanic.
- Finally, another Soldier commented that the “policy which requires internships to be restricted to DoD jobs needs to be changed.” He explained that “a lot of Soldiers want to get into things that do not translate to the DoD, such as working in pet shops.”

#### ***C.4. Conclusion***

Current instructions limited participation by Soldiers to Federal internship programs, potentially impairing the Soldiers’ healing and transition goals. Engagement of Soldiers in employment, education, and internship opportunities during their time in the WTB, and experiences gained from such opportunities, can positively influence outcomes regarding Soldier’s Career and Education Readiness transition goals and will affect how they ultimately enter and contribute to the workforce.

Extending internships to state and local government programs would expand the breadth of opportunities available to Soldiers and provide them options that are geared to their specific interests as they plan and prepare for transition to civilian life. Additionally, a Soldier who is interested in a particular internship may be more likely to stay with that program.

Subsequent to our visit, we were informed that the Office of the Secretary of Defense had drafted a DoD Instruction which would provide guidance for development and implementation of the Services on Education and Employment Initiative (E2I) and Operation WARFIGHTER (OWF), in accordance with Public Law 112-81, December 31, 2011, Section 551, “Employment Skills Training for Members of the Armed Forces on Active Duty who are Transitioning to Civilian Life.”

#### ***C.4. Recommendations, Management Comments, and Our Response***

**C.4.1. Under Secretary of Defense for Personnel and Readiness publish and implement DoD guidance for the Education and Employment Initiative for expanding internship opportunities for Soldiers assigned or attached to a WTU to the maximum extent possible in accordance with the National Defense Authorization Act for Fiscal Year 2012, Section 551 of Public Law 112-81, December 31, 2011.**

##### ***Under Secretary of Defense for Personnel and Readiness***

The Assistant Secretary of Defense Health Affairs responding on behalf of the Acting Under Secretary of Defense for Personnel and Readiness concurred with comment to our recommendation. The Assistant Secretary stated that the Office of Warrior Care Policy (WCP) published DoD Instruction (DoDI) 1300.25, “Guidance for the Education and Employment Initiative (E2I) and Operation WARFIGHTER (OWF)” on March 25, 2013. They further commented that WCP is now in the implementation phase of this recommendation and is actively working with the Military Departments to develop processes and procedures for

achieving the goals of the DoDI, and in meeting legislative requirements of the National Defense Authorization Act for Fiscal Year 2012, Section 551, of Public Law 112-81, December 31, 2011.

### ***Our Response***

The Assistant Secretary of Defense Health Affairs comments are responsive and meet the intent of the recommendation. We have obtained a copy of DoDI 1300.25, “Guidance for the Education and Employment Initiative (E2I) and Operation WARFIGHTER (OWF)” issued on March 25, 2013, and acknowledge the efforts being made to address job training, and employment skills training, including apprenticeship programs. However, in response to our final report, we request that the Assistant Secretary, provide an update on the timeline for the implementation of E2I and OWF, and describe how this initiative will be continuously monitored to ensure wounded, ill, and injured service members are afforded education, employment and internship opportunities for a successful transition.

**C.4.2. Commander, Warrior Transition Command, update command policies and provide interim measures to allow Soldiers assigned or attached to a WTU to participate in internship opportunities to the maximum extent possible in accordance with the National Defense Authorization Act for Fiscal Year 2012, Section 551 of Public Law 112-81, December 31, 2011, in supporting the Soldier’s Career and Education Readiness transition goals, as appropriate.**

### ***The Office of the Surgeon General, U.S. Army Medical Command Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comments to our recommendation. The Surgeon General stated that the Warrior Transition Command is awaiting implementing guidance from Assistant Secretary of the Army, Manpower and Reserve Affairs and Army G-1 with regard to Directive-type Memorandum 12-007. They further commented that Warrior Transition Command is prepared to update command policies and procedures to support private internships as soon as this option has Army approval and implementing guidance.

### ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request the Commander, Warrior Transition Command provide copies of signed command policies and procedures supporting Soldiers education, employment and private internship opportunities as they become available. In addition, we request that the Commander, Warrior Transition Command describe how the approved policies and procedures will be implemented throughout Warrior Transition Units.

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## **Observation D. Challenges for Madigan Army Medical Center – Madigan Healthcare System**

We identified two challenges related to WTB Soldier medical care provided by Madigan Army Medical Center which it should address in order to ensure more effective support for the care, healing, and transition of Wounded, Ill, and Injured Soldiers. They are as follows:

### **D.1. Soldiers Lengthy Transition Times**

### **D.2. Soldiers Limited Access to Specialty Medical Care**

We believe that addressing these challenges will increase the effectiveness of the Madigan Army Medical Center's leadership and staff in providing quality and timely care and services in support of recovering Soldiers to promote their healing and transition.

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## **D.1. Soldiers Lengthy Transition Times**

Madigan Army Medical Center (MAMC) exceeded the established 100-day standard spent in the Medical Evaluation Board (MEB)<sup>31</sup> phase of the disability evaluation system.

This was due in part to the lack of personnel at MAMC needed to support the high volume of military medical board cases. Additionally, Soldiers who were undergoing their MEB were not properly educated about the MEB process and the importance of the established timeline for completion and final approval.

As a result, Soldiers were confronted with lengthy transition times which had potential negative effects on some Soldiers' transition back to Active duty or to civilian status.

### ***D.1. Background***

In November 2007, the DoD and Department of Veterans Affairs (VA) initiated a joint Disability Evaluation System (DES) Pilot program to analyze and significantly improve the DES timeliness, effectiveness, simplicity, and resource utilization by integrating DoD and VA processes, eliminating duplication, and improving case management practices. The DES Pilot subsequently became the Integrated DES (IDES).

Additionally, in January 2008, the National Defense Authorization Act for Fiscal Year 2008 (NDAA FY 2008) required DoD and VA, to develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering servicemembers.

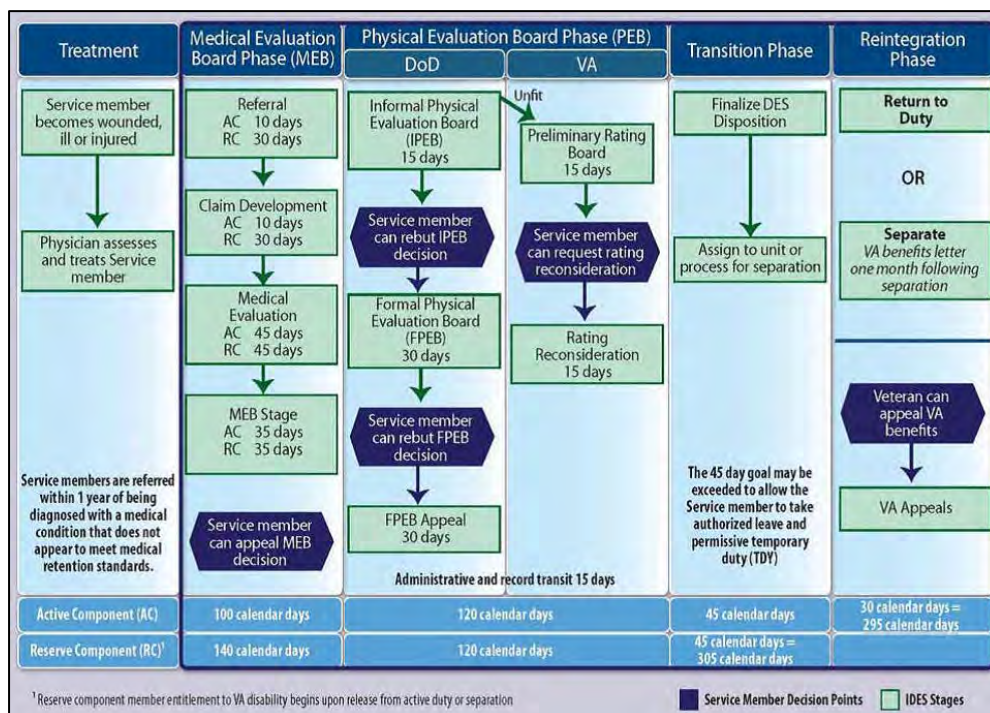
The Integrated Disability Evaluation System (IDES) features a single set of disability medical examinations intended to determine both military personnel fitness and disability and another set of disability ratings provided by the VA. The IDES consists of established timeline goals for delivering VA benefits to active duty servicemembers within 295 days and to reserve component servicemembers within 305 days of referral to the MEB.

The DoD case processing time standard for the MEB phase of the IDES is 100 calendar days for active duty and 140 days for reserve component servicemembers. The MEB is a process completed by at least two physicians who review all documentation relevant to a service member's medical history to determine appropriate diagnosis and ability to continue serving in a full-duty capacity. Figure 5 shows the Integrated Disability Evaluation System (IDES) timeline.

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<sup>31</sup> Medical Evaluation Board (MEB) is the process designed to determine whether a Soldier's long-term medical condition enables him/her to continue to meet medical retention standard. The MEB is considered an informal board process because, by itself, it does not drive any personnel actions.

**Figure 5. Integrated Disability Evaluation System Timeline**



Source: Office of Wounded Warrior Care and Transition, Directive Type Memorandum – 11-015, “Integrated Disability Evaluation System (IDES), December 19, 2011

Following our visit to JBLM WTB, the Under Secretary of Defense for Personnel and Readiness issued Directive-Type Memorandum (DTM) 11-015 – “Integrated Disability Evaluation System (IDES),” December 19, 2011. This DTM establishes policy, assigns responsibilities, and prescribes procedures for the IDES process.

## D.1. Discussion

The Integrated Disability Evaluation System was fully implemented at Joint Base Lewis-McChord (JBLM) on February 4, 2010. JBLM was established as one of three Physical Evaluation Board (PEB)<sup>32</sup> locations that reviewed Soldiers medical and duty performance evidence to make a determination of fitness to continue military service (JBLMs scope of responsibility includes all Soldiers within the Western Regional Medical Command, not just Wounded Warriors assigned or attached to WTBs).

Since the implementation of IDES at JBLM, the Medical Evaluation Board (MEB) process has been impacted by an increased MEB case load, staffing and space concerns, and delays in Soldiers’ transition times.

<sup>32</sup> The Physical Evaluation Board (PEB) formally determines fitness for continued service and eligibility for disability compensation. The other Army PEB locations are: Walter Reed National Military Medical Center, Bethesda, MD.; and Fort Sam Houston, San Antonio, TX.



A Health Care Administrator from Madigan Army Medical Center (MAMC) reported that Soldiers in the WTB spent between 327 days to 455 days from start of MEB until the packages were forwarded for PEB. The established DoD standard for moving Soldiers through the MEB process was 100 calendar days. He explained that there was no one single cause, stating that each Soldier's case was different. Causes for delay included, but were not limited to:

- A Soldier's decision to appeal;
- Independent medical reviews of MEB findings;
- Retrieval of medical and administrative documents from other units, and
- Soldiers missing medical appointments, which then required the appointments to be re-scheduled.

### **Impact of Increased Caseload**

The Health Care Administrator acknowledged other factors that impacted the IDES processing delays at MAMC, especially the sheer volume of the case load. He explained that MAMC had the second highest case load in the Army, with 1,800 active MEBs, plus 988 Temporary Disability Retired List (TDRLs)<sup>33</sup> cases.

Subsequent to our visit, complaints were made by Soldiers and Soldiers' families to their congressional representatives about practices at MAMC which resulted in PTSD disability ratings being reversed by the forensic psychiatry team. Based on these complaints, on May 16, 2012, the Secretary of the Army and Army Chief of Staff announced a comprehensive, Army-wide review of Soldier behavioral health diagnoses and evaluations at all of its medical facilities since 2001. This effort, along with the already identified backlog of MEB cases placed an additional burden on MAMC resources.

### **Staffing and Space Concerns**

The MAMC Patient Administration Division responsible for coordinating the MEB packages had insufficient staffing and space. Table 3 shows administrative personnel assigned to the MAMC MEB/ Physical Evaluation Board Liaison Officer (PEBLO)<sup>34</sup> office as of June 2011.

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<sup>33</sup> The Temporary Disability Retired List (TDRL) is a list of Army members found to be unfit for performance of military duty by reason of physical disability which may be permanent, but which has not sufficiently stabilized to permit an accurate assessment of permanent degree of disability. The law requires that a final determination be made before the fifth anniversary of placement on the TDRL. A Soldier may be removed from TDRL at an earlier date whenever a periodic examination discloses that the medical condition has stabilized for rating and duty purposes.

<sup>34</sup> The Physical Evaluation Board Liaison Officer (PEBLO) counsels Soldiers who are undergoing physical disability evaluation, provides Soldiers with authoritative and timely answers to their questions about the physical disability system, and aids them in understanding their rights and entitlements.

**Table 3. Madigan Army Medical Center Medical Evaluation Board and Physical Evaluation Board Liaison Officer Staff**

PEBLOs	Supervisor	Physicians	Physician Assistants	Medical Technicians	Support
9	1	5	2	9	6

*Source: Staffing breakout provided by Patient Administration Representative, June 14, 2011.*

We were informed that I Corps<sup>35</sup> was hiring an additional 6-assistant/PEBLOs and 5-Nurse Case Managers to separately manage the MEB cases of some 200 Soldiers in units outside the WTB.

The PEBLO is one of the most important contacts for the Service member and family members(s) throughout the IDES process. The IDES guidance recommends a PEBLO to Soldier ratio at each MTF of 1:20. The MAMC ratio for PEBLOs was 1:150, with each PEBLO managing over 100 cases at a time.

MAMC had insufficient staff to handle the 1,800 plus MEB cases, and insufficient space for existing staff and medical records. Moreover, during our interview with MAMC leadership, they voiced similar concerns regarding space constraints and manpower, stating that they would need a separate building just to house and complete the work required for processing the volume of medical records for review.

Several initiatives were in place to address the insufficient staffing and space constraint concerns. MAMC was hiring 200 PEBLOs, MEB technicians, and providers. As new hires were phased in the plan was for them to receive the requisite specialized training for their individual roles. To address space concerns, MAMC purchased and renovated 11 trailers for the newly assigned staff.

Given the excessive length of time for the IDES process, there was a need for more administrative support to copy records and to track Narrative Summary (NARSUM)<sup>36</sup> completion, as well as a need for more PEBLOs. A health care provider mentioned that there appears to be no incentive for the Soldier to get better while waiting for his or her MEB, and based on the nature of the Soldier's injuries, new health problems could arise, further prolonging their stay and delaying the MEB process. Furthermore, a legal representative commented that there was a lack of transparency in the system, noting that a Soldier cannot "see" where their package is. In addition, the representative mentioned that Soldiers needed to have a better understanding of the board processing system.

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<sup>35</sup> First Corps is one of the four Corps headquarters in the active Army, and one of three based in the continental United States. I Corps has been designated as one of the active Army's contingency corps, and stays prepared to deploy on short notice worldwide to command up to five divisions or a joint task force.

<sup>36</sup> The Narrative Summary (NARSUM) is a summary of a patient's medical history, physical examination, medical tests and results, all consultations, diagnoses, treatment and prognosis written by a physician and placed in the MEB package.

Based on our interviews, WTB Soldiers described the medical board process as “confusing and stressful.” Additionally, they cited concerns that their required paperwork was lost, including medical records, and that medical appointments took a long time to complete. Other complaints were as follows:

- “Following your VA appointments, it still took 2 to 4 weeks to get NARSUMs back.”
- “It took three months to get an appointment with forensic psychology, then three months to get a second signature which led to a lot of waiting because of a huge backlog.”
- “The process is the best it can be with so many Soldiers going through the medical board process; however, communications could be better with my PEBLO in regards to findings.”
- “I had been on the fast track with my MEB when three more units returned which caused everything to slow down. The MEB and PEB technicians are just slammed. I constantly check on the progress of my package, but everyone is so busy I always get told to wait.”

Finally, one Guard Soldier stated that this place “steals your soul and puts you in a deeper depression.” He further mentioned that the time spent at the WTB was too long, and that he could not plan for the future without a timeline to go by. “They tell me to plan for the future, but they cannot tell me when I can leave.”

### ***D.1. Conclusion***

The NDAA FY 2008 language required DoD and Department of Veterans Affairs to jointly develop and implement a comprehensive policy on improvements to care, management, and transition of recovering servicemembers.

Concerns about the length of time it took for processing the boards, evaluations, and paperwork required for Soldiers to transition continue to be addressed by the appropriate agencies. MAMC had put measures in place to hire and train new PEBLOs, MEB technicians, and providers. MAMC purchased and renovated trailers to provide additional office space for newly hired staff so they could better perform their jobs to ensure that MEBs could be processed in a timely fashion.

The mandated comprehensive, Army-wide review of Soldier behavioral health diagnoses and evaluations further impacted the challenges faced by the MAMC Patient Administration Division, not only to complete the mandated reviews but to continue processing new and ongoing MEBs and PEBs.

Despite efforts to improve the process, however, the prolonged IDES process appeared to contribute to frustrations and complaints among Soldiers which negatively impacted the Soldier and family as they prepared to transition back to Active Duty or to civilian life.

## ***D.1. Recommendations, Management Comments, and Our Response***

**D.1.1. Commander, Western Regional Medical Command track each phase of the IDES process over time to identify and act upon barriers to timely IDES completion for Soldiers assigned or attached to WTBs.**

### ***The Office of the Surgeon General, U.S. Army Medical Command Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comments to our recommendation. The Surgeon General reported that in June 2012, Western Regional Medical Command (WRMC) developed and staffed a new Integrated Disability Evaluation System (IDES) section within the Warrior Transition Office (WTO) to identify, monitor and analyze trends and conditions affecting timely and efficient disability processing for Warrior Transition Battalion Soldiers. In addition, they reported that the Veterans Tracking Application (VTA) was established as the system of record and is updated and used by IDES stakeholders, which allows the WTO to track each phase of the IDES process.

The Surgeon General stated that to improve timeliness, WRMC instituted a monthly teleconference review with military treatment facilities (MTF) to discuss WTB Soldier's cases delayed in the Medical Evaluation Board (MEB) phase for greater than 150 days. MTFs provide a detailed status update, to include planned actions and obstacles to the WTO at the time of the teleconference. The Surgeon General reported that this continuing action has resulted in a significant decrease in WTB cases delayed in the MEB phase from 218 cases on November 29, 2012 to 60 cases by March 12, 2013. The Surgeon General reported that as a result of this successful review, WRMC monthly teleconference reviews have expanded to include all WRMC Soldiers in the MEB phase of IDES greater than 150 days.

Furthermore, the Surgeon General reported that to reduce backlog and improve timely processing, a 15 member team of Soldiers was sent to provide administrative support to the VA Disability Evaluation System Rating Activity Sites (DRAS). The VA DRAS is responsible for applying disability ratings to claimed conditions acquired during service. The impact of this team will be evaluated after 6 months to determine if additional support is required.

Finally, the Surgeon General stated that in March 2013, the WTO initiated monitoring of all WTB Soldiers in the MEB phase of IDES for more than 100 days. The information will be shared during the monthly WRMC WTB Nurse Case Manager meetings. They further stated that continuous monitoring and dialogue will determine what further actions are required to improve the overall timeliness of disability processing for Soldiers.

### ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. No further action is required.

**D.1.2. Commander, Madigan Army Medical Center:**

**D.1.2.a. Identify obstacles within the MEB referral, claim development, medical evaluation, and MEB processing states that inhibit prompt MEB completion, and request additional personnel resources from WRMC that will eliminate the MEB backlog and optimize ongoing processes.**

**D.1.2.b. Request additional resources to provide sufficient space to support staff requirements for effective MEB processing.**

**D.1.2.c. Educate Soldiers and their families on the IDES process to include a realistic timeline for what the Soldier can expect once the process begins.**

**D.1.2.d. Develop a mechanism whereby a Soldier can track and be informed of his or her status in the IDES process.**

***Office of the Surgeon General, U.S. Army Medical Command  
Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comments to our recommendations. The Surgeon General stated that Madigan Army Medical Center identified multiple obstacles impacting WTB Soldiers processing times. These obstacles include: the lack of MEB personnel; extensive medical records review mandated by MEDCOM; difficulty in obtaining copies of medical records and administrative documents required to process cases; and scheduled leave for Soldiers at the referral stages.

The Surgeon General further noted that in the last 13 months, JBLM MEB has hired and trained 32 PEBLOs, 11 PEBLOs Supervisors, 36 Contact Representatives and 5 Administrative Assistants. This increase in staffing has reduced the caseload to approximately 58 cases per PEBLO. An intake team was also created to obtain original medical records, create copies, initiate contact with the Soldiers, and to identify problems early on in the case. Furthermore, they reported that in August 2012, eleven modular units were refitted as temporary office space and currently house approximately 100 staff members. Future construction is planned for a larger, 4,000 square foot building to house all MEB staff not collocated in the Brigades, as well as VA Military Service Coordinators, QTC providers, IDES Soldier's legal counsel, and others.

Finally, the Surgeon General reported that MAMC has implemented a formalized process where Soldiers and their families are educated on the IDES process. Soldiers during their initial briefing are instructed to attend their initial IDES briefing, usually within 7 days. The briefings cover all aspects of the IDES process, to include timelines. Timelines are again reviewed when the Soldier receives one-on-one counseling with their PEBLO. Additionally, the Surgeon General stated that Soldiers now have the capability to track their IDES progress via their AKO, and that data entry compliance has improved greatly over the last 13 months. Moreover, Soldiers can contact their PEBLO at any time for updates; and starting May 1, 2013, PEBLOs began monthly contacts with Soldiers to provide updates, even if there status is unchanged.

## ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendations. No further actions required.

## **D.2. Soldiers Timely Access to Specialty Medical Care**

Soldiers had difficulty in obtaining timely appointments for some specialty medical care needs, specifically, Orthopedics, Pain Management, Behavioral Health and Forensic Psychiatry.

This was due in part to the limited availability of provider resources and a lack of understanding by some Soldiers of the process for specialty medical care access.

As a result, necessary medical evaluations and treatments may have been delayed, prolonging Soldiers' transition time.

### ***D.2. Background***

MAMC is a 200-bed medical treatment facility providing both inpatient and outpatient services. Services included:

- Primary Care: Family Medicine, Pediatrics, Internal Medicine
- Specialty Care: Medical and General Surgery, Emergency Medicine, Ophthalmology, Obstetrics/Gynecology, Otolaryngology (ENT), Behavioral Health and Psychiatry, Psychology and Social Work Services, and
- Clinical Support Services: Radiology, Laboratory, Pharmacy, Preventive Medicine, and Substance Abuse Rehabilitation

The Assistant Secretary of Defense (Health Affairs) Policy Memorandum 11-005, "TRICARE Policy for Access to Care," February 23, 2011, includes referrals for Specialty Care Services, stating that beneficiaries must be offered an appointment with an appropriately trained provider within 4 weeks (28 calendar days) or sooner, if required, and within 1-hour travel time from the beneficiary's residence.

Furthermore, the Office of the Surgeon General Medical Command (MEDCOM) Policy Memo, 10-062. "MEDCOM Military Treatment Facility (MTF) Access to Care for Active Duty Service Members (ADSM), including Warriors in Transition (WT)," August 26, 2010, addressed Enhanced Access to Care for Service members as seven working days for initial specialty care. The Army Enhanced Access to Care Standard is for initial specialty care appointments at the MTF. However, referrals made to the TRICARE civilian network or to other DoD/VA medical facilities remain under the 28 calendar day standard.

### ***D.2. Discussion***

Soldiers indicated that they were satisfied with the WTB Clinic and support provided by their primary care managers (PCM). However, Soldiers reported in multiple interviews that access to specialty care was slow, and that some appointments (initial and follow up) could take up to a month or two. Soldiers' comments included:

- “Forensic Psychiatry<sup>37</sup> took three months and was a big bottleneck.”
- “The PTSD Clinic was usually backed up and the doctors seemed very busy and overworked. Despite the fact that appointments were hard to get, once you got them the quality of care was OK.”
- “The care is good; it is the logistics side that has failed. Even though the WTB has priority, his appointments and surgeries kept getting pushed back.”

There was a shortfall of services for those Soldiers with severe TBI/PTSD and various behavioral health problems. WTB senior leaders also commented that Occupational Therapy, Orthopedics, Pain Management and Forensic Psychiatry services tended to be very busy and appointments were difficult to obtain.

According to one WTB provider, access for Orthopedics, Plastic Surgery, Forensic Psychiatry and Psychology usually required a month wait. He further explained that over the past several months, the backlog of services had improved with the exception of Orthopedics, which was still the primary delay for Soldiers. The provider mentioned that the forensic psychiatry program needed to be better resourced, stating that it usually took a month for the Soldier to get a forensic psychiatry appointment, then another 3-4 months for completion of the evaluation.

Another provider mentioned that access to the hand surgeon took about a month. Access to an orthopedic surgeon could be difficult, but occasionally the Soldier could be seen by the Orthopedic Physician Assistant.<sup>38</sup> He also reported that the real bottleneck was with Forensic Psychiatry.

Finally, a nurse case manager also explained that sometimes it “could take months for a Soldier to get seen by Neurosurgery and Orthopedics.” She also mentioned that “Forensic Psychiatry could be a nightmare, taking months for physicians to complete the write-ups and even longer for the second signature review on the final paperwork.” Since 2008, MAMC had utilized a Forensic Psychiatry team to evaluate and complete behavioral health evaluations on Soldiers diagnosed with PTSD as part of the Integrated Disability Evaluation System (IDES).

Subsequent to our visit, changes have been implemented regarding utilization of Forensic Psychiatrists in evaluating Soldiers with PTSD diagnoses. The Army Surgeon General’s Office issued “Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder

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<sup>37</sup> Forensic Psychiatry is that dealing with the legal aspects of mental disorders; the branch of psychiatry that makes determinations, as regarding fitness to stand trial, the need for commitment, or responsibility for criminal behavior, in a court of law.

<sup>38</sup> A physician assistant (PA) is a medical professional who works as part of a team with a doctor. PAs perform physical examinations, diagnose, and treat illnesses; order and interpret lab tests; perform procedures; assist in surgery; provide patient education and counseling. A PA is a graduate of an accredited PA educational program who is nationally certified and state –licensed to practice medicine with the supervision of a physician.



(PTSD),” April 10, 2012. The policy outlines the responsibilities of behavioral health and medical care providers on the assessment and treatment of PTSD.

## ***D.2. Conclusion***

Access to certain specialty medical care services for some Soldiers had been lengthy and frustrating. We heard from providers that specialty services backlog had improved; however, there was still a month wait, which was within the TRICARE Access to Care standard but not the Army’s Enhanced Access to Care Standard of seven working days for initial specialty care access.

In summary, delays in receiving timely specialty medical care services impacted the Soldiers’ healing, contributed to delays in MEB processing, and further delayed their transition.

## ***D.2. Recommendation, Management Comments, and Our Response***

**D.2. Commander, Madigan Army Medical Center conduct an analysis to determine obstacles to access and delays encountered and then take appropriate steps (including increased referrals to the civilian TRICARE network) to ensure that Warrior Transition Battalion Soldiers’ access to all specialty care meets or exceeds the Army Enhanced Access to Care Standards.**

### ***Office of the Surgeon General, U.S. Army Medical Command Comments***

The Office of the Surgeon General, U.S. Army Medical Command concurred with comment to our recommendation. The Surgeon General reported that Madigan Army Medical Center (MAMC) primary care managers refer WTB Soldiers for specialty care and the assigned Nurse Case Manager books the referral with the appropriate MAMC specialty clinic. WTB Soldiers are referred to providers in the TRICARE network when enhanced access to care standards for specialty care cannot be met.

The Surgeon General further noted that as part of the monthly monitoring of enhanced access to care performance metrics, MAMC Clinical Services Division had implemented an oversight process to ensure that action has been taken to schedule a Soldier that has not been offered an appointment within the established standard. Based on these actions their most recent data analysis indicated that initial specialty consults met the enhanced access to care standard 83.4 percent of the time, which is below the MEDCOM goal of 90 percent. Reported delays were attributed to Soldier request for personal reasons, such as leave, and a lack of appointment availability.

### ***Our Response***

The Office of the Surgeon General, U.S. Army Medical Command comments are responsive and the actions meet the intent of the recommendation. No further action is required.

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## Appendix A. Scope, Methodology, and Acronyms

We announced and began this assessment on April 16, 2010. Based on our objectives, the assessment was planned and performed to obtain sufficient evidence to provide a reasonable basis for our observations, conclusions, and recommendations. The team used professional judgment to develop reportable themes drawn from multiple sources, to include interviews with individuals and groups of individuals, observations at visited sites, and reviews of documents.

We visited the Warrior Transition Battalion and Madigan Army Medical Center (MAMC) – Madigan Healthcare System located on Joint Base Lewis-McChord, Washington, from June 14-24, 2011. During our site visit we observed battalion operations and formations; viewed living quarters, campus facilities, and selected operations at the medical facility; and examined pertinent documentation. We also conducted meetings and interviews – ranging from unit commanders, staff officers, and WTB staff, to civilian staff and contractors – as shown below:

- MAMC Commander and Sergeant Major
- Deputy Commander for Nursing Services
- WTB Commander and Sergeant Major
- WTB Operations and Personnel Officers
- WTB Surgeon
- WTB Pharmacist
- WTB Company Commanders
- WTB First Sergeants
- WTB Platoon Sergeants
- WTB Squad Leaders
- WTB Primary Care Managers
- WTB Occupational Therapists
- Soldiers' MEB Counsel
- WTB Behavioral Health Licensed Clinical Social Workers
- Soldier and Family Assistance Center Director
- Physical Evaluation Board Liaison Officer
- Ombudsman
- Family Readiness Support Assistant
- Veterans Assistant Liaison
- Chief, Patient Administration Division (phone)
- Chief, Pain Management Clinic (phone)
- Traumatic Brain Injury Clinic

Further, we performed interviews with WTB Soldiers, to include 60 individual interviews with Soldiers, and 4 group interviews with additional Soldiers grouped by rank. The 4 group interviews consisted of the following participants:

- 4 Army Officer/Senior Enlisted = 4 Active and Reserve Component
- 3 Army E5 – E7 = 3 Active Component
- 9 Army E5 – E6 = 9 Reserve Component
- 10 Army E3 – E4 = 10 Active and Reserve Component

We prepared standardized sets of questions that were used during individual and group sessions, which were tailored to the type or group of personnel being interviewed. Those interviews primarily included but were not limited to recovering Soldiers and members of the Triad of Care – primary care managers, nurse case managers, and WTB squad leaders. The standardized interview questions for these groups included among others, topics such as access to care, use of

Comprehensive Transition Plans, responsibilities for Triad of Care members, working relationships amongst the Triad of Care members, and discipline issues within the WTB.

## **Use of Technical Assistance and Computer-Processed Data**

We did not use computer-processed data to perform this assessment. However, analysts from the DoD Office of the Inspector General, Deputy Inspector General for Audit, Quantitative Methods and Analysis Division, used a simple random sample approach to determine the number of Soldiers we should interview at the JBLM WTB to obtain a representative sample. The random sample was used to avoid any biases that might have been introduced by selecting interviewees non-statistically.

The analysts used a list of Soldiers identified by name, rank, and WTB company assignment (Alpha, Bravo, and Charlie Companies, and Headquarters Company), which we obtained from the JBLM WTB. As of January 31, 2011, there were 414 Soldiers at the JBLM WTB, which was the total population from which we drew our random sample.

The analysts used a program called the Statistical Analysis System and its internal random number generator to assign random values to each individual, then sorted all 414 Soldiers into random number sequence. Using this method, the analysts calculated a sample size of 59 Soldiers for individual interviews. The sample size is based on a 90 percent confidence level, a planned margin of error of 10 percent, and the statistically conservative assumption of a 50 percent error rate.

The team used this approach to first determine whether any reportable themes (noteworthy practices, good news, issues, concerns, and challenges) were identified by those most impacted by their assignment to the WTB, the Soldiers. We met and interviewed MAMC and WTB military and civilian staff, and contractors supporting the WTB – to corroborate the identified themes or to identify other reportable themes not readily known to the Soldiers.

We provided the list of Soldiers to be interviewed from our randomly generated sample to the JBLM WTB. With a requirement of 59 interviews, we advised the JBLM WTB that those 59 interview slots should be filled with Soldiers from the primary list, assigned values 1 through 65 in random order sequence until all interview slots were full. If the WTB was unable to fill all 59 slots with the primary sample provided, we provided alternates that could be used (for a total of 99 randomly selected Warriors). We further advised the JBLM WTB that a justification had to be provided for any individuals in that sequence that were unable to attend an interview for mitigating reasons such as convalescent leave, annual leave, medical appointments, physical impairments, logistical constraints, etc. Below are the results from our interviews with individual Soldier's at the JBLM WTB.

Of the 92 Soldiers statistically selected with random order numbers 1 through 99:

- 43 Soldiers from the primary list of 65 were interviewed;
- 13 Soldiers from the alternate list of 27 were interviewed;
- 4 Soldiers were interviewed, but not on a designated list, and
- 36 Soldiers were excused.

The JBLM WTB provided an acceptable excuse for all the Soldiers who were unavailable for the interviews. We believe that the information obtained from the 43 individuals selected as part of our original random sample provided a reasonable indication of the views of the total population, and we found that the views provided by the additional 17 Warriors interviewed mirrored those of the statistically selected Warriors.

## Acronym List

The following acronyms were used in this report.

AW2	Army Wounded Warrior Program
ACAP	Army Career and Alumni Program
ACS	Army Community Service
aCTP	Automated Comprehensive Transition Plan
AHLTA	Armed Forces Health Longitudinal Technology Application
AKM	Army Knowledge Management
AKO	Army Knowledge Online
ALARACT	All Army Activities
ASC	Anderson Simulation Center
AWCTS	Army Warrior Care and Transition System
BH	Behavioral Health
BRAC	Base Realignment and Closure
C2	Command and Control
CAC	Common Access Card
CBWTU	Community Based Warrior Transition Unit
CER	Career and Education Readiness
CG	Commanding General
CHTW	Coming Home to Work
CM	Case Management
CO-ADOS	Contingency Operations Active Duty for Operational Support
COTA	Certified Occupational Therapy Assistant
CONUS	Continental United States
CSF	Comprehensive Soldier Fitness
CSW	Clinical Social Worker
CTP-G	Comprehensive Transition Plan - Guidance
CTP	Comprehensive Transition Plan
CWO2	Chief Warrant Officer Two
CYS/CYSS	Child, Youth, and School Services
DCCS	Deputy Commander for Clinical Services
DES	Disability Evaluation System
DoDI	Department of Defense Instruction
DoD IG	Department of Defense Office of the Inspector General
DTM	Directive-Type Memorandum
DVA	Department of Veterans Affairs
DVBIC	Defense and Veterans Brain Injury Center
E2I	Education and Employment Initiative
E EI	Employment, Education and Internship

EFMP	Exceptional Family Member Program
ERS	Evaluation Reporting System
EXORD	Department of the Army Execution Order
FRAGO	Fragmentary Order
FTR	Focused Transition Review
GME	Graduate Medical Education
HHC	Headquarters and Headquarters Company
IDES	Integrated Disability Evaluation System
LCSW	Licensed Clinical Social Worker
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
JER	Joint Ethics Regulation
JBLM	Joint Base Lewis-McChord
MAMC	Madigan Army Medical Center
MEB	Medical Evaluation Board
MEDCOM	The United States Army Medical Command
MEDDAC	Medical Department Activity
MSC	Military Service Coordinator
mTBI	Mild Traumatic Brain Injury
MTF	Military Treatment Facility
NARSUM	Narrative Summary
NCM	Nurse Case Manager
NCO	Non-Commissioned Officer
NJP	Non-Judicial Punishment
OCO	Overseas Contingency Operations
OPORD	Operational Order
OTR	Occupational Therapist Registered
OTSG	Office of the Surgeon General
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OWF	Operation WARFIGHTER
PA	Physician Assistant
PCM	Primary Care Manager
PCS	Permanent Change of Station
PEB	Physical Evaluation Board
PEBLO	Physical Evaluations Board Liaison Officer
PMART	Pharmacy Medication Analysis & Reporting Tool
PT	Physical Therapist
PTA	Physical Therapy Assistant
PTSD	Post Traumatic Stress Disorder
RC	Reserve Component
SFAC	Soldier and Family Assistance Center
SL	Squad Leader
SOPs	Standard Operating Procedures
TBI	Traumatic Brain Injury
TCS	Temporary Change of Station

TDRL	Temporary Disability Retired List
TOL	Triad of Leadership
TRICARE	Tri-Service Medical Care
TSGLI	Traumatic Servicemember's Group Life Insurance
UCMJ	Uniform Code of Military Justice
VA	Department of Veterans Affairs
VR&E	Vocational Rehabilitation and Employment
WCTP	Warrior Care and Transition Program
WT	Warrior in Transition
WTB	Warrior Transition Battalion
WTC	Warrior Transition Command
WTU	Warrior Transition Unit
WRMC	Western Regional Medical Command

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## Appendix B. Summary of Prior Coverage

Several reports were issued during the past 6 years about Department of Defense and Department of Veterans Affairs health care services and management, disability programs, and benefits. The Government Accountability Office (GAO), the Department of Defense Inspector General (DOD IG), and the Naval Audit Service have issued 28 reports relevant to DoD Warrior Care and Transition Programs.

Unrestricted GAO reports can be accessed over the Internet at <http://www.gao.gov>.  
Unrestricted DOD IG reports can be accessed at <http://www.dodig.mil/PUBS/index.html>.  
Naval Audit Service reports are not available over the Internet.

### GAO

GAO Report No. GAO-13-5, “Recovering Servicemembers and Veterans, Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits,” November 2012

GAO Report No. GAO-12-676, “Military Disability System: Improved Monitoring Needed to Better Track and Manage Performance,” August 28, 2012

GAO Report No. GAO-12-718T, “Military Disability System: Preliminary Observations on Efforts to Improve Performance,” May 23, 2012

GAO Report No. GAO-12-27R, “Department of Defense: Use of Neurocognitive Assessment Tools in Post-Deployment Identification of Mild Traumatic Brain Injury,” October 24, 2011

GAO Report No. GAO-12-129T, “DOD and VA Health Care: Action Needed to Strengthen Integration across Care Coordination and Case Management Programs,” October 6, 2011

GAO Report No. GAO-11-551, “Defense Health Care: DOD Lacks Assurance that Selected Reserve Members Are Informed about TRICARE Reserve Select,” June 3, 2011

GAO Report No. GAO-11-572T, “Federal Recovery Coordination Program: Enrollment, Staffing, and Care Coordination Pose Significant Challenges,” May 13, 2011

GAO Report No. GAO-11-633T, “Military and Veterans Disability System: Worldwide Deployment of Integrated System Warrants Careful Monitoring,” May 4, 2011

GAO Report No. GAO-11-32, “VA Health Care: VA Spends Millions on Post-Traumatic Stress Disorder Research and Incorporates Research Outcomes into Guidelines and Policy for Post-Traumatic Stress Disorder Services,” January 24, 2011

GAO Report No. GAO-11-69, “Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed,” December 6, 2010

GAO Report No. GAO-09-357, “Army Health Care: Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed,” April 20, 2009

GAO Report No. GAO-09-31, “Defense Health Care: Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements,” October 31, 2008

GAO Report No. GAO-08-635, “Federal Disability Programs: More Strategic Coordination Could Help Overcome Challenges to Needed Transformation,” May 20, 2008

GAO Report No. GAO-08-615, “DOD Health Care: Mental Health and Traumatic Brain Injury Screening Efforts Implemented, but Consistent Pre-Deployment Medical Record Review Policies Needed,” May 30, 2008

GAO Report No. GAO-08-514T, “DOD and VA: Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers,” February 27, 2008

GAO Report No. GAO-07-1256T, “DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers,” September 26, 2007

GAO Report No. GAO-06-397, “Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers,” May 11, 2006

## **DOD**

Department of Defense Recovering Warrior Task Force, 2011-2012 Annual Report, August 31, 2012

Department of Defense Recovering Warrior Task Force, 2010-2011 Annual Report, September 2, 2011

## **DOD IG**

DOD IG Report No. DODIG-2012-120, “Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion – West Headquarters and Southern California Units,” August 22, 2012

DOD IG Report No. DODIG-2012-067, “Assessment of DOD Wounded Warrior Matters – Camp Lejeune,” March 30, 2012

DOD IG Report No. SPO-2011-010, “Assessment of DOD Wounded Warrior Matters – Fort Drum,” September 30, 2011

DOD IG Report No. SPO-2011-004, “Assessment of DOD Wounded Warrior Matters – Fort Sam Houston,” March 17, 2011

DOD IG Report No. IE-2008-005, “DoD/VA Care Transition Process for Service Members Injured in Operation Iraqi Freedom/Operation Enduring Freedom,” June 12, 2008

DOD IG Report No. IE-2008-003, “Observations and Critique of the DoD Task Force on Mental Health,” April 15, 2008

### **Army**

Army Audit Report No. A-2011-0008-IEM, “Army Warrior Care and Transition Program,” October 21, 2010

### **Navy**

Naval Audit Service Report No. N2009-0046, “Marine Corps Transition Assistance Management Program - Preseparation Counseling Requirement,” September 15, 2009

Naval Audit Service Report No. N2009-0009, “Department of the Navy Fisher Houses,” November 4, 2008

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## Appendix C. Reporting Other Issues

We performed the Assessment of DoD Wounded Warrior Matters at four Army locations and two Marine Corps locations and reported on each location separately. This assessment report focused on whether the programs for the care, management, and transition of Warriors in Transition at the Joint Base Lewis-McChord Warrior Transition Battalion (WTB), Washington, were managed effectively and efficiently.

Additionally, in the future we may report on issues, concerns, and challenges that were common among the 6 sites visited, and that were identified as systemic issues. These reports will be provided to appropriate organizations to provide information on or identify corrective actions addressing those issues, concerns, and challenges. Those organizations may include but are not limited to the Under Secretary of Defense for Personnel and Readiness; the Assistant Secretary of Defense for Health Affairs; the U.S. Army Medical Department, Office of the Surgeon General; the U.S. Army Medical Command, Warrior Transition Command; and others as required.

This appendix captures issues, concerns, and challenges we identified that may be included in future report(s). Refer to the table below for some potential report topics.

**Table 1. Potential Report Topics**

<b>Issue, Concerns, and Challenges</b>	<b>Report Reference(s)</b>
Selection and Training of Leaders and Cadre of Warrior Transition Units	N/A
Medication Management	N/A
Assessment of Navy and Air Force Wounded Warrior Programs	N/A
Management of National Guard and Reserve Recovering Service Members Healthcare Delivery	B.1., pages 24-25
Timely Access to Specialty Medical Care	D.2., pages 59-61
Service-level Management of the Integrated Disability Evaluation System (IDES)	D.1., pages 51-58

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## Appendix D. Army Guidance for Warrior Transition Units

Army guidance for the care and management of Warriors is contained in the “Warrior Transition Unit Consolidated Guidance (Administrative),” March 20, 2009 (hereafter, “Consolidated Guidance”). It was revised in March 20, 2009 to update policies and guidance for the care and management of Warriors. According to the Consolidated Guidance, a Warrior is a Soldier who is assigned or attached to a Warrior Transition Unit (WTU) whose primary mission is to heal.

The Consolidated Guidance addresses specific policy guidance regarding assignment or attachment to a WTU, the process for the issuance of orders to Soldiers, and other administrative procedures for Soldiers being considered for assignment or attachment to a WTU. The publication also summarizes existing personnel policies for family escort, non-medical attendant, housing prioritization, leave, and other administrative procedures for Soldiers assigned or attached to a WTU. Further, it provides information on the Physical Disability Evaluation System for Soldiers processing through this system.

Pertinent Federal statutes, regulations, and other standards governing these programs and services are cited throughout the Consolidated Guidance and are collated in a reference section. The document also states that, previously, there was no overarching Army collective or regulatory administrative guidance for WTUs.

The authority for WTUs is provided by:

- Department of the Army EXORD [Execute Order] 118-07 Healing Warriors, June 21, 2007.
- Department of the Army FRAGO [Fragmentary Order] 1 to EXORD 118-07 Healing Warriors, August 16, 2007.
- Department of the Army FRAGO 2 to EXORD 118-07 Healing Warriors, December 14, 2007.
- Department of the Army FRAGO 3 to EXORD 118-07 Healing Warriors, July 1, 2008.

The overview of the WTU program is stated as:

- Vision – to create an institutionalized, Soldier-centered WTU program that ensures standardization, quality outcomes, and consistency with seamless transitions of the Soldier’s medical and duty status from points of entry to disposition.
- Goal – to expeditiously and effectively evaluate, treat, return to duty, and/or administratively process out of the Army, and refer to the appropriate follow-on healthcare system, Soldiers with medical conditions.
- Intent – to provide Soldiers with optimal medical benefit, expeditious and comprehensive personnel and administrative processing, while receiving medical care. The Army will take care of its Soldiers through high quality, expert medical care. For those who will leave the Army, the Army will administratively process them with speed and compassion. The Army will assist with transitioning Soldiers’ medical needs to the Department of Veterans Affairs for follow-on care.

The objectives of the WTU program are stated as:

- “Address and ensure resolution on all aspects of personnel administration and processing for the WT [a Warrior] from points of entry through disposition, to include processing through the Physical Disability Evaluation System (PDES). Final disposition occurs when the WT is determined/found medically cleared for duty or the PDES process is complete, including appeals.”
- “Address and ensure resolution on the administrative aspect of medical management for the WT, including Tri-Service Medical Care (TRICARE) and/or Veterans Health Administration follow on medical care.”
- “Address and ensure resolution on command and control (C2), including logistical support, for the WT assigned or attached to garrison units, Medical Treatment Facilities (MTF), Warrior Transition Units (WTU), and Community-Based Warrior Transition Unit (CBWTU).”<sup>39</sup>
- “Address and ensure resolution on the accountability and tracking of the WT in real time as he/she progresses through the WT process and if necessary, the PDES process.”

The Mission Essential Task List of the WTU program states that the Army will–

- “Provide Command/Control and Administrative Support (including pay) trained to focus on special needs of WT Soldiers.”
- “Provide high quality, expert medical care, and case management support - Primary Care Provider, Case Manager, Behavioral Health, Specialty Providers.”
- “Administratively process with speed and compassion those who will leave the Army.”
- “Facilitate transition of separating and REFRAD’ing [Release From Active Duty] Soldiers to the VHA [Veterans Health Administration] or TRICARE for follow-on care.”

The WTU concept of operations is stated as:

- “Provide Soldiers high-quality living conditions.”
- “Prevent unnecessary procedural delays.”
- “Establish conditions that facilitate Soldier’s healing process physically, mentally, and spiritually.”
- “Provide a Triad of Warrior Support that consist of Platoon Sergeant/Squad Leader, Case Manager (CM), and Primary Care Manager (PCM), working together to ensure advocacy for WT Soldiers, continuity of care and a seamless transition in the force or return to a productive civilian life.”

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<sup>39</sup> Community-Based WTUs are primarily for Reserve Component Soldiers. Community-Based WTU is a program that allows Warriors to live at home and perform duty at a location near home while receiving medical care from the Tricare network, the Department of Veterans Affairs, or Military Treatment Facility providers in or near the Soldier’s community.



## Appendix E. Office of the Surgeon General Policy Guidance for the Comprehensive Transition Plan

The Office of the Surgeon General Medical Command Policy Memo 11-098, November 29, 2011, “Comprehensive Transition Plan (CTP) Policy,” stated that all Soldiers, regardless of CTP track, will complete six CTP processes. These processes overlap, interrelate, and include multiple interconnected feedback loops. All Soldiers will complete in-processing, phase I goal setting training, initial self-assessment, CTP track selection, and initial scrimmage within 30 days of arrival at a WTU, which will be documented using the automated CTP, counseling records, and AHLTA<sup>40</sup>. Specifically, these six processes included:

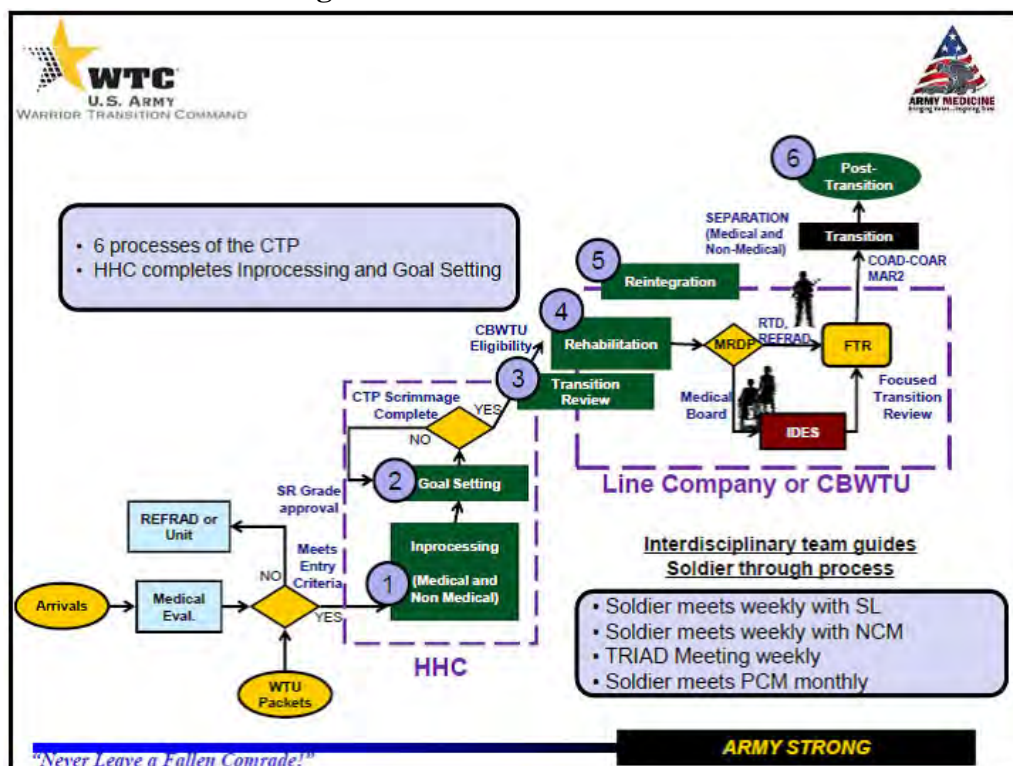
- In-processing – lays the foundation for integration into the WTU/CBWTU and initiates the CTP
- Goal Setting – guides the Soldier and his Family in the development of sub-goal (short-term) and transition outcome goal (long-term). The Specific, Measurable, Actionable, Realistic, and Time Bound (SMART) Action Statements provides the Soldier a roadmap that supports healing and transition
- Transition Review – provides the interdisciplinary team with an opportunity to review Soldier goals and progress with a focus on identifying and resolving issues that are impeding goal attainment. This process includes self-assessment and scrimmage steps:
  - Self-Assessment – designed to facilitate weekly discussions between the Soldier and his Squad leader or Platoon Sergeant and Nurse Case Manager
  - Scrimmage – a formal meeting with the Soldier’s interdisciplinary team that uses six domains of strength (career, physical, emotional, social, Family and spiritual) to develop and refine a future oriented Transition Plan
  - Focused Transition Review (FTR) – a formal meeting that is similar to scrimmage, but focuses more on the transition plan progress and development of a new plan to track remaining actions and sub-goals. Acts more as a feedback and an after action review of the process for each Soldier and the supporting interdisciplinary team
  - Synchronization of the scrimmage and FTR timelines – FTR’s augment and provide additional company and battalion level focus to quarterly scrimmages

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<sup>40</sup> Armed Forces Health Longitudinal Technology Application (AHLTA) is the clinical information system that generates and maintains a lifelong, computer-based outpatient record for every Soldier, Sailor, Airman, and Marine; their family members; and others entitled to DoD military care who receives care in a military treatment facility.

- Rehabilitation – provides appropriate clinical and non-clinical interventions to support the Soldier's transitional goals
- Reintegration – designed to specifically prepare each Soldier and his Family for a successful transition back to the force or to civilian life as a Veteran
- Post-transition – refers to the period after a soldier has exited the WTU/CBWTU. The Soldier is under the guidance of his gaining unit, the VA, and/or the AW2<sup>41</sup> Program, if eligible. Figure 1 illustrates the six processes of the CTP as described above.

**Figure 1. CTP Process Flowchart**


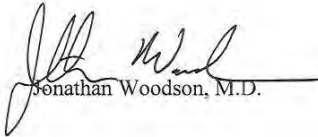


Source: Warrior Transition Command, Comprehensive Transition Plan Policy and Guidance – December 1, 2011

<sup>41</sup> Army Wounded Warrior (AW2) is an Army program that assists and advocates for severely wounded, ill, and injured Soldiers, Veterans, and their Families, wherever they are located, regardless of military status. The system of support and advocacy uses a non-medical case management model to help guide severely wounded, injured, and ill, Soldiers from evacuation, through treatment, rehabilitation, return to duty or military retirement and transition into the civilian community. AW2 works inside the network of Army, Government, and local and national resources to help Soldiers and Families resolve many issues and foster independence into the next stage of their lives.

## Appendix F. Management Comments

### Assistant Secretary of Defense Health Affairs

	<b>THE ASSISTANT SECRETARY OF DEFENSE</b>
	1200 DEFENSE PENTAGON WASHINGTON, DC 20301-1200
<b>HEALTH AFFAIRS</b>	May 20, 2013
MEMORANDUM FOR DEPUTY INSPECTOR GENERAL, SPECIAL PLANS AND OPERATIONS, DEPARTMENT OF DEFENSE INSPECTOR GENERAL	
SUBJECT: Response to the Department of Defense Inspector General Draft Report (Project No. D2010-D00SPO-0209-005) Titled, "Assessment of DoD Wounded Warrior Matters Joint Base Lewis-McChord"	
This is the Department's response to the Department of Defense (DoD) Inspector General Draft Report on (Project No.D2010-D00SPO-0209-005) titled, "Assessment of DoD Wounded Warrior Matters – Joint Base Lewis-McChord" dated April 1, 2013.	
We appreciate the opportunity to provide the attached comments on the draft report.	
Please direct any questions to the point of contact on this matter, Ms. Sandra Mason. <span style="background-color: black; color: black;">[REDACTED]</span>	
	 Jonathan Woodson, M.D.
Attachment: As stated	

**Response to DoD IG DRAFT report (Project No. D2010-D00SPO-0209.005) titled  
"Assessment of DoD Wounded Warrior Matters – Joint Base Lewis-McChord,"  
April 1, 2013**

**RECOMMENDATION:**

**C.4.1.** Under Secretary of Defense Personnel and Readiness publish and implement the Department of Defense (DoD) guidance for the Education and Employment Initiative for expanding internship opportunities for Soldiers assigned or attached to a WTU to the maximum extent possible in accordance with the National Defense Authorization Act for Fiscal Year 2012, Section 551 of Public Law 112-81, December 31, 2011.

**RESPONSE:**

The Office of Warrior Care Policy (WCP) concurs. WCP published DoD Instruction (DoDI) 1300.25, "Guidance for the Education and Employment Initiative (E2I) and Operation WARFIGHTER (OWF)" on March 25, 2013. WCP is now in the implementation phase of this recommendation and is actively working with the Military Departments to develop processes and procedures for achieving the goals of the DoDI.

**EXCERPTS FROM DoDI 1300.25:**

Enclosure 2, paragraph 4 states " The Deputy Assistant Secretary Defense for Wounded Care Policy, DASD (WCP), under the authority, direction, and control of the Assistant Secretary of Defense for Health Affairs (ASD (HA)), shall:

a. Manage E2I and provide oversight of its implementation and guidance for continuous process improvement.

(1) Be responsible for coordination of support programs among the Military Departments, United States Special Operations Command (USSOCOM), the Veterans Administration , and the Department of Labor (DOL).

(2) Oversee the implementation of OWF, a federal government internship program for Recovering Service members (RSMs) on active duty, and make policy recommendations to USD (P&R), as necessary.

b. Synchronize all programs and processes throughout the DoD that support E2I and OWF, including those provided by the Military Departments and USSOCOM. Recommend changes to policy and operational procedures to the USD (P&R), as necessary.

c. Ensure each Military Department and USSOCOM has policies and procedures in place to provide education and employment support services and resources for RSMs.

d. Coordinate the consultation and collaboration with other federal entities to maximize RSM access to all available support services and resources.

e. Establish policies and procedures for the implementation of E2I and OWF in accordance with References (a) and (f).

f. Develop methodology and standards for data collection and reporting in accordance with DoD Manual 8910.1 (Reference (k)), establishing metrics that measure effectiveness of E2I and OWF activities.

g. Oversee the execution of E2I and OWF efforts through the (Recovery Coordination Program (RCP) in accordance with Reference (f), ensuring staff is appropriately trained to support RSMs throughout the range of care.

h. Serve as the principal point of contact for the DoD Components on all E2I and OWF policy matters.

i. Develop strategic guidance and program goals to ensure proper administration, outreach, and management of the Office of the Secretary of Defense (OSD) E2I and OWF.

j. Develop standardized training for the Military Departments and USSOCOM to support the integration for E2I into current programs.

k. To the extent authorized by law and DoD regulations, engage with private-sector entities to facilitate the formation of partnerships to enhance employment opportunities.

l. Develop process to ensure compliance with Privacy Act requirements in the maintenance and dissemination of personally identifiable information of RSMs.”

Further, Enclosure 2, paragraph 6 states: “The Secretaries of the Military Departments shall:

a. Ensure their respective Wounded Warrior programs provide appropriate training to the necessary personnel to support the integration of E2I into the RCP.

(1) Maintain operational, tactical, and administrative control of their non-medical personnel providing services to RSMs to ensure execution of roles and responsibilities as specified in this Instruction.

(2) Ensure that the DoDWounded Warrior and the Family Support Programs execute the policies of this Instruction.

b. Identify RSM candidates ready to participate in educational and employment activities.

c. Provide a Service liaison, when requested, to WCP to ensure each Services’ interests are addressed.

d. Provide access to military installations in accordance with DoD regulations and the regulations of the Service-concerned, for Warrior Transition Organizations (WTOs) for OSD E2I, OWF, and other federal agency support personnel in order to synchronize education and

employment resources. When requested, provide facilities for E2I and OWF support personnel on military installations, including but not limited to office space, communication, and IT infrastructure on space-available basis.

e. Provide a Service liaison at locations where there are large populations eligible for E2I in order to facilitate government and community support relationships in that region.

f. Ensure private sector internships, apprenticeships, and other forms of on-the-job training are identified through a fair and equitable process, allowing for equal access to organizations and RSMs through OWF, to avoid any appearance of preferential treatment and/or conflict of interest, in accordance with Decision Type Memorandum 12-007 (Reference (m)).

g. When possible, identify internal employment opportunities for transitioning RSMs. Utilize applicable civilian hiring authorities to facilitate the placement of transitioning RSMs into appropriate positions.”

h. Identify and provide for internal OWF internship opportunities for RSMs.

i. Assist the DASD (WCP) in implementing E2I and OWF to Reserve Components, to the extent possible through the RCP.

j. In promulgating implementing regulations, the Secretaries of the Military Departments concerned shall authorize Commander, USSOCOM, to establish and carry out such programs for eligible Service members assigned to USSOCOM.

**ACTION OFFICER:** [REDACTED]

## The Office of the Surgeon General, U.S. Army Medical Command



REPLY TO  
ATTENTION OF

DEPARTMENT OF THE ARMY  
OFFICE OF THE SURGEON GENERAL  
7700 ARLINGTON BOULEVARD  
FALLS CHURCH, VA 22042-5140

06 MAY 2013

MCIR

MEMORANDUM FOR Department of Defense Inspector General, Special Plans and Operations, ATTN: Dr. Elias Nimmer, 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Reply to DODIG Draft Report, Assessment of Wounded Warrior Matters, Joint Base Lewis-McChord (Project No. DODIG 10SP-0209.005)

1. Thank for you the opportunity to review this report. Our comments are enclosed for your consideration.

2. Our point of contact is Ms. Carmen C. Bryan, [REDACTED]

FOR THE SURGEON GENERAL:

Encl

DAVID A. BITTERMAN  
Colonel, MS  
Chief of Staff



**U.S. Army Medical Command (MEDCOM) and  
Office of the Surgeon General (OTSG)**

**Comments on DODIG Draft Report  
Assessment of DOD Wounded Warrior Matters – Joint Base Lewis-McChord  
(Project No. D2010-D00SPO-0209.005)**

**TECHNICAL COMMENT:**

Page 45, Discussion section. Madigan Army Medical Center (MAMC) implemented the Integrated Disability Evaluation System on 4 February 2010, not 1 March 2010 as stated in the report.

**RECOMMENDATION C.1.1.:** Commander, Human Resources Command in coordination with the Commander, Warrior Transition Command (WTC) develop policy guidance to direct Active and Reserve Component Soldiers who volunteer for Warrior Transition Battalion (WTB) leadership and cadre positions to attend WTB cadre and staff training prior to, or in route, to their assignment at the WTB.

**RESPONSE:** Concur. Human Resources Command issued MILPER Message 12-006, Warrior Transition Unit (WTU) Cadre Assignments, on 9 January 2012 requiring approved cadre to attend the WTU Cadre Resident Course enroute to assignment whenever possible (see attachment 1, page 3, para 12). When not feasible to attend the course enroute, attendance will be completed 90 days of assuming a cadre position. This course gives new WTU leaders an overview of select policies and doctrine, and current command level issues, initiatives, and guidance. Pending WTC guidance requires Squad Leaders and Platoon Sergeants are required to attend the Cadre Resilience Course the week prior to attending the WTU Resident Course. The Cadre Resilience Course (CRC) helps cadre develop critical thinking, knowledge, and skills to overcome challenges and bounce back from adversity. Another focus of the course is to help cadre understand how to use course material to mentor WTU Soldiers and create a more resilient environment for healing and transition.

**RECOMMENDATION C.1.2.:** Commander, United States Army Medical Department Center and School (AMEDDC&S) in coordination with the Commander, Warrior Transition Command, evaluate the effectiveness of the WTB leadership and cadre training program to ensure that the course for cadre includes a robust training curriculum and ongoing educational training opportunities. Also, to ensure that the Triad of Care team members and WTB support staff are appropriately prepared to deal with the unique mission challenges of helping Soldiers to recover, and transition back to active duty or return to civilian life.

Encl



**RESPONSE:** Concur. The AMEDDC&S continually evaluates the effectiveness of the WTB leadership and cadre training program and has noted issues associated with large instructor-to-student ratios and the lack of an Army-approved Table of Distribution and Allowances (TDA).

More practical, situational training, and in-depth behavioral health training is suggested by this report and further supported by independent assessments performed by the Department of the Army Inspector General and the AMEDDC&S Quality Assurance Office, as well as collaboration between WTC and the AMEDDC&S. However, effective instructor-to-student ratios are required to ensure robust training curriculum and ongoing educational training opportunities.

The AMEDDC&S participated in a MEDCOM manpower analysis and review during FY12. The resulting proposed TDA supports increased manpower, and is currently awaiting approval from the US Army Manpower Analysis Agency approval.

In addition, AMEDD evaluation of program effectiveness is supported by the following:

- Curriculum committee meetings to review training curriculum. The last review was held on 15 November 2012 and identified a need for lower instructor-to-student ratios. The next curriculum review will occur in FY 13, followed by an update of the formal programs of instruction.
- End-of-course surveys are completed after each course iteration and are reviewed by the Academy of Health Sciences (AHS) Warrior Transition Department staff and the AMEDDC&S Quality Assurance Office staff on a regular basis.
- Informal collaboration between the AMEDDC&S and WTC on hot topics provides immediate feedback as needed.
- Post-graduate surveys are under development, with a projected implementation by 30 August 2013 to further evaluate the effectiveness of the blended learning training program.
- The distributed learning orientation course for all assigned WTU was recently developed with implementation expected by 30 June 2013.
- A new distributed learning course to replace the current prerequisite course requirement for resident training is being developed and will embrace enhanced learning activities (interactivity levels 2 and 3). The projected completion date is 1 October 2015.
- The AMEDDC&S implemented response technology and large group scenario-based training to enhance the training experience in the lessons of Risk

Communication, Integrated Disability Evaluation Systems (IDES), Post Traumatic Stress, Operational Stress Management, Command and Control. The use of Smartboard technology is used to reinforce learning in IDES and CTP.

In addition, to better equip cadre to deal with unique mission challenges, the AMEDDC&S and WTC implemented Cadre Resilience training that all Squad Leaders and Platoon Sergeants attend in conjunction with the Cadre Course. Also, a minimum of one cadre per company attends the Master Resiliency Training. As stated above, WTC and the AMEDDC&S are working together to create an orientation training course to support distributed learning that any cadre member can access on the enterprise Army Learning Management System. WTC plans to begin placing modules online by 30 August 2013.

In order to help Soldiers to recover, and transition back to active duty or return to civilian life, WTC placed civilian Transition Coordinators (TC) in each of 17 WTBs to support employment, education, and internship program opportunities for Soldiers. TCs support the career track and goal of each transitioning Soldier with appropriate activities. They are training on Career and Education Readiness (CER) and Comprehensive Transition Program (CTP) elements in a variety of venues, including the WTC Annual Training Conference; Senior Leader/Clinical Leader training held at WTC; and through monthly online training sessions which cover a variety of topics. Unit occupational therapists, along with TCs, support a continuum of non-clinical case management related to CTP career goals for each Soldier. Coordination of services with Veterans Association Vocational Rehabilitation and Employment counselors; Army Career Alumni Program and Army Education counselors; and Department of Labor employment representatives ensures each Soldier gets the resources to succeed in their CTP goals. Early coordination with government agencies is intended to ensure a successful transition of needed services once the Soldier transitions out of the Army.

**RECOMMENDATION C.2.1.a.:** The Assistant Secretary of the Army, Manpower and Reserve Affairs in coordination with the Commander, Warrior Transition Command evaluate current and future manning requirements of Warrior Transition Units to ensure they are appropriately staffed to meet the mission and have experienced cadre in place to effectively manage and support Soldiers during their healing and transition.

**RESPONSE:** Concur. WTC conducts periodic reviews of the Warrior Transition Unit (WTU) Table of Distribution and Allowance (TDA). During this process, WTUs are structured based on forecasted Warrior in Transition (WT) population. The forecast models Pre-Deployment, Theater Evacuation, and Post-Deployment gains into the WTU population while accounting for actual deployment schedules into the future. This process ensures WTUs are adequately designed to support WT population increases on installations, but also allows the TDA to be streamlined for installations with WT populations trending downward. WTC is also revising the cadre assignment policy to ensure best-qualified personnel are selected to be cadre.

In addition, WTC received approval to continue to fill Contingency Operation for Active Duty Operational Support positions as required, and use 2-year permanent change of station orders instead of 1-year orders.

These actions should ensure appropriate staffing to meet the mission and effectively manage and support Soldiers during their healing and transition.

**RECOMMENDATION C.2.1.b.:** The Assistant Secretary of the Army, Manpower and Reserve Affairs in coordination with the Commander, Warrior Transition Command: Conduct an analysis to determine if Warrior Transition Units/Warrior Transition Battalions have adequate personnel resources and funding to support appropriate manpower levels, ongoing staff training requirements, and support services in order to maintain optimal staffing levels and ratios.

**RESPONSE:** Concur. In December 2012, the US Army Manpower Analysis Agency (USAMAA) validated the WTU Ratio Determination Model for use in determining manpower requirements for all WTUs and Community Care Units. USAMAA approved the model application for 3 years (see attachment 2).

With the significant decrease in supplemental funding occurring now through FY 15, funding for Reserve Component Soldiers continue to be an issue. Therefore, WTC requested DA consider an alternate sourcing solution to continue required Reserve Component support.

**RECOMMENDATION C.3.1.a.:** Commander, Warrior Transition Command complete the migration of the Comprehensive Transition Plan from the Army Knowledge Online to the Army Warrior Care and Transition System.

**RESPONSE:** Concur. Migration of the Comprehensive Transition Plan (CTP) from Army Knowledge Online to the Army Warrior Care and Transition System was completed in June 2012, in accordance with timeline provided in Annex A to WTC OPORD 11-10 (see attachment 3).

**RECOMMENDATION C.3.1.b.:** Commander, Warrior Transition Command review the Comprehensive Transition Plan policy and guidance for relevance and effective content in supporting Soldier and Family transition needs.

**RESPONSE:** Concur. WTC will review and update CTP policy and guidance by 31 December 2013. Lessons learned from the field and leaders will be incorporated to ensure Soldiers and Families receive the best transition assistance and care possible.

**RECOMMENDATION C.3.2:** Commander, Warrior Transition Battalion evaluate the effectiveness of the WTB leadership and cadre in actively engaging the Soldiers' CTP and encourage Soldiers' involvement and adherence to the plan for a successful transition.

**RESPONSE:** Concur. In accordance with Comprehensive Transition Plan (CTP) Policy, 1 December 2011 and Summary Changes, 1 October 2012, the Comprehensive Transition Plan is a future-oriented action plan developed by the Soldier with assistance from the Nurse Case Manager. Once the transition plan is developed, execution is facilitated by the TRIAD.

The center of gravity of the WTB is the CTP, with adherence as the decisive point. Key components of the CTP are: Phase 1 Goal Setting; Initial Scrimmages; Follow-On Scrimmages; Focused Transition Reviews; and, most importantly, Self Assessments. Self Assessments facilitate weekly discussions between the Soldier and Nurse Case Manager, Platoon Sergeant, and Squad Leader. The Soldier's self-assessment and subsequent validation are the foundation of Follow-On Scrimmages and Focused Transition Reviews.

In order to ensure effective engagement in the Soldiers' CPT and encourage Soldiers' involvement and adherence for a successful transition, the CTP management analyst will provide weekly by name reports to the appropriate Company Commander for each Soldier:

- Exceeding 30 days without having Phase 1 Goal Setting completed and confirmed by the Commander via the Army Warrior Care and Transition System (AWCTS).
- Who haven't completed Self Assessments in accordance with designated frequency.
- With a Self Assessment not validated by the Nurse Case Manager.
- With a Self Assessment not validated by the Platoon Sergeant/Squad Leader.

In addition, Nurse Case Managers will attach signed scrimmage worksheets to the Soldiers AWCTS file for Initial Scrimmages, Follow-On Scrimmages and Focused Transition Reviews. This will serve as a record and facilitate TRIAD collaboration for the six domains with associated challenges, action statements, and sub-goals.

The WTB will implement these actions immediately, and the Senior Nurse Case Manager will follow up monthly in AWCTS to ensure compliance.

WTC will further assist with evaluating effectiveness of WTB leadership through the Operational Inspection Program (OIP) and command and staff visits. The OIP uses the CTP, Army Regulations, and other documents as a basis for inspection. Results are communicated to the Senior Commander in a formal outbrief to ensure that the entire Triad of Leadership (Senior Commander, Medical Treatment Facility, and WTB Commander) has awareness.

**RECOMMENDATION C.4.2:** Commander, Warrior Transition Command, update command policies and provide interim measures to allow Soldiers assigned or attached to a WTU to participate in internship opportunities to the maximum extent possible in accordance with the National Defense Authorization Act for Fiscal Year 2012, Section 551 of Public Law 112-81, December 31, 2011, in supporting the Soldier's Career and Education Readiness transition goals, as appropriate.

**RESPONSE:** Concur with comment. WTC is awaiting implementing guidance from ASA M&RA and Army G-1 with regard to DTM 12-007. WTC is prepared to update command policies and procedures to support private internships as soon as this option has Army approval and implementing guidance.

**RECOMMENDATION D.1.1:** Commander, Western Regional Medical Command track each phase of the IDES process over time to identify and act upon barriers to timely IDES completion for Soldiers assigned or attached to WTBs.

**RESPONSE:** Concur. During June 2012, Western Region Medical Command (WRMC) developed and staffed a new Integrated Disability Evaluation System (IDES) section within the Warrior Transition Office (WTO) to identify, monitor and analyze trends and conditions affecting timely and efficient disability processing for Warrior Transition Battalion Soldiers. The Veterans Tracking Application (VTA) was established by as the system of record for selected measures by HQDA EXORD 80-12, 17 February 2012. It is updated and used by IDES stakeholders, including Physical Evaluation Board Liaison Officers; the Physical Evaluation Board (PEB); and the VA Disability Evaluation System Rating Activity Sites (DRAS), and allows the WTO to track each phase of the IDES process.

To improve timeliness, the WRMC instituted a monthly teleconference review with military treatment facilities to discuss each case where a WTB Soldier's case is delayed in the MEB phase greater than 150 days. MTFs complete detailed status information, including planned actions and obstacles prior to the teleconference, and the WTO provides immediate guidance as each case is reviewed during the teleconference. This

continuing action has resulted in a significant decrease in WTC cases delayed in the MEB phase from 218 cases on 29 November 2012 to 60 cases by 12 Mar 2013 (see attachment A, WRMC WTU Soldiers over 150 Days in MEB Phase).

As a result of this success, WRMC expanded this monthly teleconference review to include all WRMC Soldiers in the MEB phase of IDES greater than 150 days, beginning 29 March 2013 (see attachment 4, Tasking 130308-03).

A backlog at the VA DRAS, used for applying disability ratings to claimed conditions acquired during service, has been identified as an additional barrier to timely processing. MEDCOM is sending 15 Soldiers to provide administrative support beginning 6 May 13. The impact of this team will be evaluated after 6 months to determine if more support is needed.

In March 2013, the WTO also began monitoring all WTB Soldiers in the MEB phase of IDES for more than 100 days, and will provide this information to the WTBs each month during the WRMC WTB Nurse Case Manager meeting. This information will be used to determine what other actions could further improve the overall timeliness of disability processing for Soldiers.

**RECOMMENDATION D.1.2.a:** Commander, Madigan Army Medical Center identify obstacles within the MEB referral, claim development, medical evaluation, and MEB processing states that inhibit prompt MEB completion, and request additional personnel resources from WRMC that will eliminate the MEB backlog and optimize ongoing processes

**RESPONSE:** Concur. Obstacles that have slowed the process for the WTB Soldiers included lack of MEB personnel (large case loads up to 250 per PEBLO); MEDCOM medical records review mandated taskers (February 2012 – August 2012); difficulty in obtaining copies of medical records and administrative documents required to process cases; and scheduled leave for Soldiers at the referral stage.

To resolve the issue of staffing in the last 13 months JBLM MEB has hired and trained 32 PEBLOs, 11 PEBLOs Supervisors, 36 Contact Representative and 5 Administrative Assistants (see attachment 5). This has reduced the caseload to approximately 58 cases per PEBLO. We have created an Intake team whose responsibility is to obtain all original medical records, create copies and initiate contact with the Soldiers. This team identifies any early problems in the case so that they are addressed.

MAMC and the WTB are working together to create a process which will expedite required documentation for processing of cases.



**RECOMMENDATION D.1.2.b.:** Commander, Madigan Army Medical Center request additional resources to provide sufficient space to support staff requirements for effective MEB processing.

**RESPONSE:** Concur. During August 2012, eleven modular units were refitted as temporary office space and currently house approximately 100 staff members. Construction of a larger, 4,000 square foot building is planned to begin by 31 December 2013 and will house all MEB staff not collocated in the Brigades, as well as VA military service coordinators; QTC providers; IDES Soldier's legal counsel; and possibly ombudsmen.

**RECOMMENDATION D.1.2.c.:** Commander, Madigan Army Medical Center educates Soldiers and their families on the IDES process to include a realistic timeline for what the Soldier can expect once the process begins.

**RESPONSE:** Concur. During the initial meeting, the MAMC intake team instructs Soldiers to attend their initial briefing. Briefings are held every Tuesday, and Soldiers normally attend within 7 days. The briefing covers all aspects of the IDES process, including timelines (see attachment 6, slides 7-9). Timelines are discussed again when Soldiers receive one-on-one counseling session with their PEBLO.

**RECOMMENDATION D.1.2.d.:** Commander, Madigan Army Medical Center develop a mechanism whereby a Soldier can track and be informed of his or her status in the IDES process.

**RESPONSE:** Concur. Soldiers can track their progress via their AKO as this reflects the data entered into eDES (see attachment 7, AKO screenshot). Data entry compliance has improved greatly over the last 13 months. The Soldier may also contact their PEBLO at anytime in the process to seek an update. Beginning 1 May 2013, PEBLOs will begin contacting Soldiers via phone and/or email and provide monthly updates, even if there is no change in status (see attachments 4 and 8).

**RECOMMENDATION D.2.:** Commander, Madigan Army Medical Center conduct an analysis to determine obstacles to access and delays encountered and then take appropriate steps (including increased referrals to the civilian TRICARE network) to ensure that Warrior Transition Battalion Soldiers' access to all specialty care meets or exceeds the Army Enhanced Access to Care Standards.

**RESPONSE:** Concur. Primary Care Managers refer WTB Soldiers for specialty care, and the assigned Nurse Case Manager books the referral with the appropriate MAMC

specialty care clinic. When enhanced access to care standards for specialty care cannot be met at MAMC, WTB Soldiers are referred to providers in the TRICARE network.

MAMC analysis using March 2013 data showed initial specialty consults met the enhanced access to care standard 83.4 percent of the time. Delays are attributable to Soldier request for personal reasons, such as leave, and a lack of appointment availability.

The MAMC Clinical Services Division monitors enhanced access to care performance on a monthly basis. In addition, a MAMC administrative officer, in conjunction with the WTB Surgeon, has oversight of the Warrior Transition Clinic and will ensure CSD awareness when a Soldier has not been offered an appointment within the standard. CSD will act immediately to correct the situation. CSD is available to address access concerns from primary care managers, nurse case managers, or Soldiers when they cannot be resolved at the local level.



# Special Plans & Operations

Provide assessment oversight that addresses priority national security objectives to facilitate informed, timely decision-making by senior leaders of the DOD and the U.S. Congress.

## General Information

Forward questions or comments concerning this assessment and report and other activities conducted by the Office of Special Plans & Operations to [spo@dodig.mil](mailto:spo@dodig.mil)

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